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

Progress Report for Health-Related Coronial Recommendations

Biannual Report – August 2020

Acknowledgements

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

The patients and their families

The Office of the State Coroner, Western Australia

The Office of the Chief Psychiatrist, Western Australia

Department of Health staff, Western Australia

Health Service Provider's Executive Medical, Safety, Quality and Performance Units

All WA health system staff involved

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

Contents

Abbreviations

ADF	Australian Defence Force
ATSI	Aboriginal and Torres Strait Islander
CLU	Coronial Liaison Unit
CRC	Coronial Review Committee
DOH	Department of Health
ED	Emergency Department
EMHS	East Metropolitan Health Service
FASD	Fetal Alcohol Spectrum Disorder
GP	General Practitioner
HSP	Health Service Provider
ICU	Intensive Care Unit
NaCS	Notifications and Clinical Summaries
RACGP	Royal Australian College of General Practitioners
RTPM	Real Time Prescription Monitoring
SCSI	System Clinical Support and Innovation Unit
SJOG	St John of God
WA	Western Australia
WACHS	WA Country Health Service
WAPHA	WA Primary Health Alliance

Introduction

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

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

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

Executive Summary

This report includes details about the implementation of recommendations on two ongoing cases: Matthew Neil Hardy Tonkin and James Ronald Chi. This report also includes information relating to the implementation or consideration of recommendations for 2 new cases, Paul Strange and Jason James Sutherland Mallett.

There was a total of 8 recommendations for the cases in this report that were relevant to the WA health system. Of these 8 recommendations, 3 have been duly considered, actioned appropriately by health stakeholders and marked as complete or closed; and, 5 recommendations are ongoing at the time of this report. Progress will be updated on the ongoing recommendations in the next biannual report.

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

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

In addition to health-related coronial inquests with recommendations, the Coronial Review Committee (CRC) also considers health related coronial inquest findings where no recommendation is made. The CRC considers such inquests to identify opportunities for WA health system learnings and recognise where there is a need to implement improvements across the system. New cases with no health-related recommendations that were considered by the CRC during this reporting timeframe include: Dylan James Riley; Valerie Kelly; Hassan Bechara; Norman Alexander Hazelgrove; Eric Wumbie; and Benedict Chifley David Candy.

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

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

Coronial inquests with recommendations

TONKIN

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

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

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

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

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

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

August 2020 update

The Chief Pharmacist has progressed the status of a real time prescription monitoring (RTPM) system. After a series of stakeholder workshops to inform impact assessments for legislative amendments to include Schedule 4 medicines in real time prescription monitoring programs, the Department of Health has regulatory amendments awaiting approval. These mandate the transmission of prescription related information from clinical prescribing systems into Prescriptions Exchange Services and collected into the National Data Exchange (NDE). As at July 2020, WA received an agreement from the Commonwealth Government for entry and use of the NDE. The entry into the NDE remained scheduled to occur in 2020.

The recommendation to liaise with the Department of Defence to consider a procedure to allow for the timely transfer of medical records of ADF members and veterans to treating medical professionals in WA was considered by the CRC. Correspondence was progressed to the Commonwealth Department of Health to seek advice on any previous or planned activities in the transfer of ADF medical records. The Federal Minister for Health responded acknowledging the

issues highlighted in the coronial inquest findings, the relevance to the Australian Digital Strategy and committed to discuss sharing Defence health information with the Minister for Defence.

The CRC members agreed that the recommendation has been considered, actioned and deemed it completed.

CHI

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

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

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

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

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

The WA Country Health Service (WACHS) has advised that whilst long term residential psychiatric care for aged care clients is infrequently required in the Kimberley region, options are available utilising existing local resources. WACHS considered the circumstances of the inquest and the inability to place him in long-term supported accommodation was considered an extremely rare event. The WACHS Mental Health Team prefers to develop individual options if and when such circumstances arise to best meet an individual's need.

The CRC members agreed that the recommendation has been considered and deemed it closed.

STRANGE

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

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

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

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

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

The East Metropolitan Health Service (EMHS) has reviewed the findings and recommendations. They have established an EMHS Care Coordination Working Group to revise the current Care Coordination in Mental Health Policy to address a number of the recommendations. EMHS have also undertaken significant work with discharge summary compliance. With respect to ensuring staff are familiar with the key policies, the EMHS Mental Health Quality Improvement Program will establish and review policy awareness processes at orientation as well as an ongoing nature.

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

MALLETT

Jason James Sutherland Mallett was being treated for mental health issues as an involuntary patient at the time of his death at Sir Charles Gairdner Hospital. He died 3 March 2017, aged 46, as a result of sudden cardiac arrhythmia on the background of significant pre-existing heart disease.

The inquest focussed on the medical treatment provided during his admission to Sir Charles Gairdner Hospital and to identify whether his heart disease should have been identified, and whether his monitoring was adequate.

The Coroner found the medical care was of a generally high standard and made one recommendation for additional measures be implemented for patients to have pulse oximetry in a psychiatric setting, where a patient is cooperative to its use. This would assist staff to monitor patients who have recently been agitated and then sedated.

The Department of Health's Coronial Review Committee (CRC) has reviewed these findings. The CRC members discussed the previous inquests that were similar to this inquest with a sedative being provided to the mental health patient prior to death. The members weighed the benefits of the pulse oximetry with the practicality, increase risk of ligatures and alert fatigue when considering the observation requirements. Members concluded that the most appropriate arrangement for medical observations for such patients would be based on the clinical risk judgement of the health professionals dealing with each patient on a case-by-case basis.

Members considered the recommendation and deemed it closed.

Coronial inquests with no health-related recommendation

Between 1 January 2020 and 30 June 2020, the CRC considered the following new coronial inquests where no health-related recommendation was made: Dylan James Riley; Valerie Kelly; Hassan Bechara; Norman Alexander Hazelgrove; Eric Wumbie; and Benedict Chifley David Candy.

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).

The following is an overview of WA health system action taken in response to a previous case (Gerda Theresia Dunkel) that was reported in the February 2020 progress report. Further information was provided since the last report.

Dunkel

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

The CLU sought advice from St John of God (SJOG) Murdoch on any actions that have been implemented since this case and received a response that a number of actions have been undertaken. These included:

- SJOG Metabolic and Obesity Surgery Department Meeting being established to provide governance across all SJOG hospitals that provide metabolic and obesity surgery. The meeting is attended by all relevant clinicians and monitors clinical outcomes and provides a mechanism for peer review of cases.
- SJOG 'Guidelines for Metabolic and Obesity Surgery' have been revised and sets out criteria for patient selection and added the requirement to discuss cases that fall outside of the criteria with the Director of Medical Services.
- A clinical audit to monitor compliance with the revised guidelines was established and will be conducted on an annual basis.

The CLU was able to ascertain information about the broader activities in bariatric surgery across the WA health system. The WA public health system has made an ongoing commitment to address the health burden caused by being overweight or obese. The WA Healthy Weight Action Plan 2019-2024 provides a roadmap for action over the next five [5] years to support people who are at risk, or currently living with overweight and obesity to achieve better health. The development of a clinical framework for the delivery of obesity services in the WA public health system, including a comprehensive care pathway, is supported and included as an action within the plan.

Bariatric Surgery is currently accessible through the WA public health system and provided according to the WA Health Bariatric Surgery Plan and mandatory access criteria. The System Clinical Support and Innovation Unit (SCSI) has undertaken a broad review of current clinical evidence including health, safety and cost benefits associated with bariatric surgical procedures in collaboration with a range of internal and external stakeholders. The review has highlighted increasing evidence that bariatric surgery is not generally successful as a stand-alone procedure and that well developed pathways are recommended for increased long-term success.

Local consultation with subject matter experts has indicated strong support for the development of a comprehensive care pathway which encompasses a holistic approach to assessment; intervention; surgery; and maintenance options for people experiencing obesity.

The SCSI review has culminated in the development of a proposed WA Obesity Services Clinical Framework, which provides a 'gold standard' for the management of obesity in the WA public health system. A Comprehensive Care Pathway for Obesity Management, detailed within the framework, proposes that an individual cannot be referred directly for bariatric surgery; they are referred to a comprehensive multidisciplinary assessment and management service whereby surgery is a considered option.

The framework also incorporates revised access criteria for bariatric surgery in WA public hospitals. The revision of the criteria aims to strengthen patient safety and clinical quality based on literature, best practice and stakeholder feedback in alignment with other Australian jurisdictions. Importantly the revised access criteria dictate that aspects of assessment be performed by a weight assessment and management service. This process ensures individuals would be deemed clinically safe and psychologically ready before being considered for bariatric surgery. It should be noted that the framework is currently undergoing the approval process. Any approved change would need to be enacted through a systemwide policy amendment.

Due to the complexity and scale of the clinical framework and comprehensive care pathway, a Pilot is planned to trial and evaluate elements of the care pathway once endorsed. The Obesity Assessment and Management Service Pilot Project will focus on the surgical assessment component of the pathway, and is anticipated to include:

- A mandatory education program to ensure individuals are aware of the full impact bariatric surgery may have on their lives, and
- A multidisciplinary assessment to optimise appropriate candidate selection for bariatric surgery against established eligibility criteria.

A robust evaluation of the pilot service would be conducted with a view to embed the Comprehensive Care Pathway for Obesity Management into practice across WA public health services.

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