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

From death we learn 2019

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Acknowledgements

The patients and their families
Ms Ros Fogliani, State Coroner, Western Australia
Mr Barry King, Deputy State Coroner, Western Australia
Ms Evelyn Vicker, Ms Sarah Linton and Mr Michael Jenkin, Coroners, Western Australia
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The Office of the State Coroner, Western Australia
The Office of the Chief Psychiatrist, Western Australia
The Health Services' Safety, Quality and Performance Units
All medical and nursing staff involved in the reporting and review of death

Contents

Background

Office of the State Coroner

The office of the Coroner is one of the oldest known to law, with the responsibility to investigate sudden or unexpected deaths continuing to this day. The current system reflects the original commitment to the deceased and the community but also extends to the deceased's family and friends. The *Coroners Act 1996* recognises the stress and trauma experienced by family and friends of a loved one who died suddenly or unexpectedly and requires the Coroner to ensure that a counselling service is offered by the court.

Under the *Coroners Act 1996* the Coroner seeks to determine the cause and manner of death and any contributing factors - a comprehensive fact-finding exercise, that as such, can be a lengthy process. The investigative process is held in accordance with the principles of open justice and is not aimed at apportioning blame.

An ancillary function of the Coroner, but a nonetheless important component of the investigative process is the identification of strategies to improve public health and/or safety; ultimately to prevent the reoccurrence of similar situations when possible. To this end the coroner may make recommendations aimed at preventing deaths in similar circumstances.

It should be noted that by the time many cases reach inquest, appropriate measures have already been implemented by Health Service Providers to improve patient safety. This information is of significant assistance to the Coroner and, properly undertaken, demonstrates the on-going commitment of health services to continually improve and adapt to better meet the needs of the public and provide safe, high-quality services.

Lessons from inquests

High quality organisations and systems routinely utilise both internal and external processes to review and improve their services, with coronial inquests being one important external mechanism from which to learn. This is the fourteenth edition of *From Death We Learn*, produced by the Coronial Liaison Unit at the Department of Health, which covers health-related coronial inquest findings from the 2019 calendar year as published on the Coroner's Court website as of 1 July 2020.

The cases are provided to assist in stimulating patient safety discussions across health disciplines. Organisations and individual health care providers are encouraged to consider these cases in the context of their service, with a quality improvement lens, seeking to identify opportunities for improvement, using a no-blame culture. Whilst each inquest summary only provides a glimpse of some of the issues, if readers are interested, the full inquest findings can be accessed on the website of the Coroner's Court of Western Australia.

As per previous years' editions, this edition includes key messages and discussion points, extracting what the Coronial Liaison Unit believes to be the significant health-related learnings from a coronial inquest. Also provided in this edition are suggested further reading and resources, to further enhance individual and organisational learnings.

Acknowledgements to the friends and families of loved ones whose deaths have been investigated by the Coroner. It is with the utmost respect to them that this publication is collated in the hope that it will complement the death prevention and public safety role of the Coroner, and ultimately improve the safety and quality of care delivered to patients.

Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Healthcare
ADF	Australian Defence Force
ADHD	attention deficit hyperactivity disorder
ARMS	At-Risk Management System
BAU	behavioural assessment units
BMI	Body Mass Index
CCTV	Closed Circuit Television
CCU	Crisis Care Unit
CLU	Coronial Liaison Unit
CPAP	continuous positive airway pressure
CPR	cardiopulmonary resuscitation
CRC	Coronial Review Committee
CTO	community treatment order
ECG	electrocardiogram
ED	emergency department
ERRCD	Electronic Recording and Reporting of Controlled Drugs
DoJ	Department of Justice
DVT	deep vein thrombosis
FASD	Fetal Alcohol Spectrum Disorder
FOI	Freedom of Information
GP	General Practitioner
GTN	glyceryl trinitrate
HSP	Health Service Provider
ICU	Intensive Care Unit
IDC	Immigration Detention Centres
IV	intravenous
IVC	inferior vena cava
IHMS	International Health and Medical Services
HDU	high dependency unit
HSP	Health Service Provider
MHA	Mental Health Assessment unit
MHC	Mental Health Commission
MHEC	mental health emergency centres
MHERL	Mental Health Emergency Response Line
MHOA	Mental Health Observation Area
OSA	obstructive sleep apnoea
PCS	Prison Counselling Service
PHS	Prison Health Service
PIC	Poisons Information Centre
PRAG	Prisoner Risk Assessment Group
PSSU	Patient Safety Surveillance Unit
PTSD	post-traumatic stress disorder
RACGP	Royal Australian College of General Practitioners
RPBS	Repatriation Schedule of Pharmaceutical Benefits
RTPM	real time prescription monitoring
SAMS	Support and Monitoring System
SHU	Special Handling Unit
SPI	Specialists in Poisons Information
TAPNA	Toxicology and Poisons Network Australia

TICC	trauma informed custodial care
VF	ventricular fibrillation
VRO	violence restraining order
WACHS	WA Country Health Service
WAPHA	WA Primary Health Alliance

Introduction to the Coronial Liaison Unit

The Coronial Liaison Unit (CLU) sits within the WA Department of Health and consists of the Chief Medical Officer, Patient Safety Surveillance Unit (PSSU) Manager as well as PSSU Senior Clinical Advisor(s) and Senior Policy Officer(s). The CLU was established in 2005 as a health initiative to improve communication between the WA health system and the Office of the State Coroner. The CLU facilitates the allocation of health-related findings from coronial inquests for implementation by Health Service Providers.

The CLU, in conjunction with the Coronial Review Committee (CRC), reviews all public inquests that have a health care aspect to them and communicates the recommendations via the Chief Medical Officer to the appropriate area within the WA health system.

The CRC operates in connection with the CLU by providing executive strategic support. The Committee 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 to the CLU, to assess the progress or completeness of strategies implemented in response to coronial recommendations.

Expert advice and stakeholder responses on the recommendations and actions taken to improve patient safety are fed back to the State Coroner in a biannual progress report.

The CLU continues to work with the Office of the State Coroner to share lessons learned from mortality review to improve future patient care.

Introduction to inquested cases

Under the *Coroners Act 1996* every regional magistrate is contemporaneously a coroner. However, in practice the majority of Western Australian inquests in 2019 were conducted by the State Coroner Ms Rosalinda Fogliani, Deputy State Coroner Mr Barry King, and Coroners Ms Evelyn Vicker, Ms Sarah Linton and Mr Michael Jenkin.

There were 2,452 deaths reported to the Office of the State Coroner for full investigation in the 2018-19 financial year, an increase from 2017-18 (n=2,291).[1] There were 2231 deaths in 2017-2018 that were dealt with by review of the treating doctor's death certificate recording a cause of death and were accepted by the coroner. This was a slight decrease from the previous year (2259 in 2017-18). In 2018-19, 61 investigations were finalised by public inquest, with 31 of these being mandated in accordance with the *Coroners Act 1996*.

Public inquests are judicial proceedings conducted in open court. The coroner is a judicial officer and receives evidence that is relevant to the inquiry. The objective of an inquest is to establish the facts surrounding the death of the person; the coroner must not appear to determine any question of civil liability or to suggest any person is guilty of an offence.

After taking the evidence at an inquest, a coroner must find, if possible:

- the identity of the deceased
- how the death occurred
- the cause of death and
- the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1998 (WA)*

Where an inquest is mandated, for example, in the case of an involuntary mental health patient, the coroner must also comment on the quality of the deceased's supervision, treatment and care.

The coroner may also make comments and/or recommendations regarding any matter connected with the death, including public health or safety or the administration of justice. For example, comments may be made about the provision of health care or the actions of other public sector agencies. Where the death is of a person 'held in care' (which includes involuntary mental health patients, prisoners and persons in the custody of police officers, amongst others), a coroner is required to comment on the quality of the supervision, treatment and care of the person while in that care.

The Coronial Liaison Unit notes all coronial recommendations pertaining to health care and provides regular reports to the Office of the State Coroner outlining the responses to each recommendation from relevant stakeholders. These responses have been included in this report where the timeframe has allowed a response to be formulated prior to publication. In accordance with agreement from the members of the Coronial Review Committee to increase transparency and accountability, as of August 2019, the executive summary of the biannual 'Progress Report for Health-Related Coronial Recommendations' (WA Health's report to the State Coroner) has been made available publicly online[2].

[1] Office of the State Coroner. Annual Report: 2018-2019 [internet]. 2019. Government of Western Australia. Accessible at https://www.coronerscourt.wa.gov.au/_files/Annual_Report_2018_2019.pdf
[2] https://ww2.health.wa.gov.au/Articles/A_E/Coronial-Liaison-Unit

Deaths of young people and children in remote region

Key Message

- Suicide is often part of a broader complex social problem of which physical and mental health are components
- Efforts to reduce suicide require addressing social determinants including inequality and intergenerational trauma
- Fetal alcohol spectrum disorder (FASD) does not exist in isolation, but exists alongside multiple other factors including early attachment disturbances and trauma which have lifelong impacts. A diagnosis of FASD alone is not indicative of the severity of impairment or the magnitude of the need for care and treatment

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

All died from ligature compression of the neck (hanging), and the manner of death was determined to be suicide for 12 of the children and young people. There was an open finding into the manner of death for the 13th child as it may have been due to misadventure rather than suicide. The deaths occurred in nine communities, with four communities suffering more than one loss.

The Coroner noted that "Given the multifactorial problems that have been experienced in the Kimberley Region for generations, there is no justification for finding that the act or omission of a particular person, officer or agency caused or contributed to a suicide" and that "No adverse comment is made against any family member. These are the people who have themselves endured significant trauma and disadvantage"[3].

Common themes for the 13 children and young people and their families

Their families had lives marred by the effects of long-standing trauma, leading in some cases to alcohol abuse as an attempt to deal with distress. For many of them, the level of alcohol abuse in the home compromised the ability of the parents to properly care for their children and they were placed in the care of other family members, with informal and often fragmented care arrangements. Alcohol and marijuana use were 'normalised' behaviour for some of the young people and four of the children.

None of the young people had been diagnosed with fetal alcohol spectrum disorder (FASD), but the Coroner considered that some of them might have had FASD based on prenatal alcohol exposure and early developmental difficulties.

[3] https://www.coronerscourt.wa.gov.au/_files/inquest-2019/13-Children-and-Young-Persons-in-the-Kimberley-Region-Finding.pdf

Most of the children and young people had no contact with mental health services, though most had voiced suicidal ideation. In some cases, this behaviour was 'normalised' for that person. Many had been exposed to prior suicides in their families and communities.

Many of the children and young people were exposed to domestic violence in the home. Extra-familial sexual abuse was alleged in respect of two male children.

Many of the children and young persons who were reviewed suffered from largely preventable medical conditions that can be related to substandard living conditions, such as recurrent skin, ear, respiratory and gastrointestinal infections, failure to thrive and anaemia. Some of these conditions can have a significant negative impact on a child's long-term health and development, predisposing the person to hearing loss and impaired learning ability, diabetes, heart and kidney disease, and premature death.

Inquest findings and comments

Aboriginal Australians experience higher levels of morbidity and mortality from mental illness, psychological distress, self-harm and suicide than other Australians. The suicide rate in the Kimberley is amongst the highest in the world, 3-4 times the national average. While the majority of Aboriginal people who die by suicide have not been diagnosed with a mental illness, this does not mean they have not suffered from mental ill health.

The prevalence of suicide in the Kimberley Region cannot be explained by a medical model of causation alone but involves the ongoing impact of colonisation, unresolved trauma, entrenched socio-economic disadvantage, cultural disruption, systemic social exclusion and disempowerment, boredom, hopelessness and despair. Suicide and self-harm are tragic symptoms not only of mental illness, but also of underlying inter-related social, historical and political factors which are not modifiable by the mental health interventions currently available in the Kimberley. Additionally, there is a different nature to Aboriginal suicide compared to non-Aboriginal suicide. There is a strong correlation between depression and suicide among non-Aboriginal people whereas this is not the case in Aboriginal people. Impulsivity plays a strong element in suicide for Aboriginal people and gives some insight into why there is no history of contact with mental health services.

The Kimberley Regions' Child and Adolescent Psychiatrist gave evidence on the effects of trauma leading to a high prevalence of developmental disorders that may have a mental health comorbidity. High levels of stress hormones in utero can affect the expression of genes, and these epigenetic processes can affect brain development, such that babies can be born hardwired to preferentially employ "fight and flight" coping strategies as they develop, at the cost of executive brain functioning, which facilitates emotional regulation. Parents' capacity to manage and develop their child's emotional regulation can be severely impacted by their own experience of trauma; parents and carers who have experienced trauma are less able to be protective of themselves and their children; when exposed to threats they may adopt dissociation, learned helplessness strategies or become the aggressor, and these strategies expose the child to a greater risk of abuse and victimisation.

Children born into communities that continue to suffer from intergenerational trauma are more likely to themselves experience prolonged or multiple exposures to individual traumatic events, arising from illness, accidents, hospitalisation or death of close family members, exposure to violence, family disintegration and financial stress. Childhood experience of trauma can have severe and long-lasting effects. It can permanently affect brain development diminishing executive function and slowing down a child's development. In some traumatised children survival mechanisms take priority over healthy growth and development, at a high cost to their mental and

physical wellbeing. Such children are more likely to go on to adopt self-destructive behaviours that include alcohol and drug abuse. Researchers have noted a link between childhood trauma and suicide.

In the Kimberley and in other regions, health is influenced by many social factors – poor educational outcomes, endemic unemployment and lack of employment opportunities, lack of income, limited access to culturally appropriate health services, poor living environments, and social exclusion. As such, the Aboriginal communities in the Kimberley experience higher rates of chronic health problems and a higher mortality rate compared to the non-Aboriginal community.

For Aboriginal people, disadvantage is shaped by accumulated life experiences of social, economic and cultural inequality and exclusion, the loss of lands and languages, and the forced removal and relocation of children from family and cultural settings. Colonisation and some previous government interventions have had lasting negative impacts on Aboriginal people.

The Coroner referred to the work of Chandler and Lalonde on suicide in First Nations young people in British Columbia and the protective factors they identified which include:

- Achievement of a measure of self-government;
- Aboriginal title to traditional lands
- A measure of local control over health
- A measure of local control over education
- A measure of local control over policing services
- Community facilities for the preservation of culture
- A measure of local control over child welfare services
- Having elected councils composed of more than 50% women

The ATSISPEP (Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project) Report in 2016 summarised the evidence-base for what works in community-led suicide prevention. Three types of suicide interventions were identified as being success factors in the area of suicide prevention - Universal, Selective and Indicated interventions, as follows:

1. Universal interventions are Indigenous community-wide response and include:
    a. prevention that aims to prevent the risk factors for suicide, by addressing “upstream” risk factors for suicide such as alcohol and drug use, family dysfunction and other challenges to wellbeing
    b. primary prevention that aims to prevent a completed suicide or suicide attempt occurring, for example community education to support help-seeking behaviour
2. Selective interventions – aimed at groups who are identified as being at higher risk of suicide, and this includes Indigenous children and young persons
3. Indicated interventions – aimed at individuals who are identified as being at higher risk of suicide, or who have attempted suicide. Accessibility of services could be lifesaving and access to Indigenous or culturally competent staff may also be important to the success of an intervention or response.

In WA the Ministerial Council for Suicide Prevention leads the state-wide suicide prevention strategy*, Suicide prevention 2020: Together we can save lives*, and oversees initiatives to improve strength and resilience, expand community understanding of suicide, and support capacity building in communities at risk.

The effects of intergenerational trauma upon Aboriginal persons and communities are not generally understood in the wider community, and service providers need to adapt their programs to account for this. The diversity of Aboriginal peoples is to be recognised in connection with the

offering of the programs. The Coroner acknowledged that there are difficulties inherent in providing services to small dispersed remote communities.

Coroner's recommendations

The Coroner made 42 recommendations aimed at preventing similar deaths, through healing and supporting these marginalised and disadvantaged communities.

WA health system action

The National Fetal Alcohol Spectrum Disorder Strategic Action Plan 2018-2028 has been developed by the Commonwealth Government in consultation with a range of groups including the WA Department of Health. The Plan seeks to improve the prevention, diagnosis, support and management of FASD in Australia.

The WA Department of Health contributed to the whole of WA State Government response to the inquest of the deaths of 13 Aboriginal children and young persons in the Kimberley Region that was led by the Department of Premier and Cabinet. A Statement of Intent on Aboriginal Youth Suicide was initially released in May 2019 as an interim response on the issue of Aboriginal youth suicide and outlined the plans for engagement and meaningful partnerships with Aboriginal people and key stakeholder groups, including the existing groups: Kimberley Suicide Prevention Working Group and Closing the Gap Interim Working Group.

In March 2020, the Commitment to Aboriginal Youth Wellbeing was released as the WA State Government's response to the State Coroner's Inquest and the 2016 Parliamentary Inquiry into Aboriginal youth suicide, Learnings from the Message Stick. The response addressed a combined 86 recommendations from the two reports and accepted, accepted in principle, or were already implementing, 71 of the recommendations. None of the recommendations were rejected, some were superseded, and others required further investigation.

The Commitment to Aboriginal Youth Wellbeing outlines a set of 12 individual commitments to take a holistic approach to Aboriginal youth wellbeing, focusing on, and grouped into, four key areas:

- **Cultural Wellbeing**
  1. Culturally responsive government
  2. Respect and appreciation for Aboriginal culture
  3. Supporting cultural programs
- **Health**
  4. Better prevention, intervention and postvention services
  5. Building capacity in health and mental health services
  6. Better access to clinical services
- **Community**
  7. Support for community wellbeing
  8. Building local capacity
  9. Better engagement with education
- **Youth**
  10. Helping young people connect to culture
  11. Building youth capacity
  12. A voice for young people

It represents a long-term commitment to Aboriginal children and youth, not just in the Kimberley, but across the State, and will be delivered in partnership with the Aboriginal community. The

Government will table annual reports in Parliament on the progress of its commitments and implementation of all 86 of the Coroner's and Message Stick recommendations.

References

- 13 Deaths of Children and Young Persons in the Kimberley Region[4]
- Statement of Intent on Aboriginal Youth Suicide May 2019[5]
- Commitment to Aboriginal Youth Wellbeing March 2020[6]
- Suicide Prevention 2020: Together we can save lives[7]
- Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSIPEP)[8]
- ATSIPEP – Final report 2016[9]
- National FASD Strategic Action Plan 2018-2028[10]

Further reading and resources

- Report of the Message Stick Inquiry[11]
- Aboriginal youth wellbeing – Department of Premier and Cabinet[12]

[4] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_13_deaths_of_children_and_young_persons_in_the_kimberley_region.aspx
[5] https://www.wa.gov.au/organisation/department-of-the-premier-and-cabinet/aboriginal-youth-wellbeing
[6] https://www.coronerscourt.wa.gov.au/_files/inquest-2020/Commitment%20to%20Aboriginal%20Youth%20Wellbeing.pdf
[7] https://www.mhc.wa.gov.au/about-us/strategic-direction/suicide-prevention-2020-together-we-can-save-lives/
[8] https://www.atsisepp.sis.uwa.edu.au/
[9] https://www.atsisepp.sis.uwa.edu.au/#final-report
[10] https://www.health.gov.au/resources/publications/national-fetal-alcohol-spectrum-disorder-fasd-strategic-action-plan-2018-2028
[11] https://www.wa.gov.au/government/publications/report-of-the-message-stick-inquiry
[12] https://www.wa.gov.au/organisation/department-of-the-premier-and-cabinet/aboriginal-youth-wellbeing#update-on-progress

Discussion points

- What gaps exist in health outcomes between Indigenous and non-Indigenous groups? What factors contribute to these? How can our health planning consider these gaps?
- Have there been any targeted interventions to address disparate health outcomes? What impact have they had? Are there any unintended outcomes?
- The Coroner made several recommendations relating to FASD. What is the utility of a formal diagnosis of FASD compared to a broader neurodevelopmental functional assessment?
    - What are the drawbacks and barriers to each approach?
    - Is there a standardised, culturally appropriate and validated diagnostic tool that can be used to assess Aboriginal people in remote regions?
- How likely is it that your service provides care to people with FASD? How are their needs considered?
- How can healthcare be provided more equitably across sparsely populated regions?
- What has your workplace done to improve cultural competency and cultural safety?
- How can your workplace incorporate principles of co-design and collaboration with your patients?
- The Government's 'Commitment to Aboriginal Youth Wellbeing' provides Commitments for Health (No. 4-6) relating to prevention, capacity and access.
    - Consider and review your health service in this regard
- How can you and your service improve its Youth Focus?

Suicides in detention

Key Messages

- Detention centres can have a disproportionately adverse impact on some inmates and cannot provide an appropriate therapeutic environment for people with mental health issues or alcohol and drug problems
- Detention centres have a paucity of health resources. There are insufficient forensic mental health beds for the State, especially for female prisoners
- A perceived or real loss of control during prolonged detention can cause long-lasting trauma

Suicides in prison

The provision of mental health care in the Western Australian prison system had previously been reviewed in a series of inquests held into deaths that occurred in 2014 and 2015. The coroners found that five men and one woman had completed suicide by various methods in three different prisons. In 2019, further inquests were held into more deaths in various prisons.

In 2016, the Inspector of Custodial Services noted "WA's prison system is chronically overcrowded"[13] with a high rate of imprisonment, the highest rate of Aboriginal incarceration in the country, a growing number of prisoners with serious health and mental health issues, and under-resourcing of key health and mental health services. The number of prisoners held in the prison system and the proportion of those who are on remand awaiting sentencing has increased over recent years with little or no increase in space or resources.

The strong link between adverse childhood events and personality and mental health disorders, risk of imprisonment and suicide was discussed at the inquests. The prevalence of mental disorders and substance abuse disorders in prisoners is much higher than in the general population, often co-occurring in the context of multiple social problems. More than half of Aboriginal prisoners had experienced the death of a close family member in the previous 12 months. More than one third of women in prison reported being the victim of sexual or physical violence.

Case 1

The deaths of five male prisoners in the State's major male maximum security prison were investigated together in one inquest. The inquest focused on the supervision, treatment and care provided to the five men while they were prisoners, as well as the circumstances of their respective deaths. The Coroner heard evidence about the management of at-risk prisoners, some of the risk factors impacting on prisoner management and the strategies and tools employed to address those factors.

The State's major male maximum security prison consists of 14 cell blocks, separated by security fencing. Eight of these contain specialist units including the Special Handling Unit (SHU) and the Crisis Care Unit (CCU).

The CCU contains 12 ligature-minimised cells with Closed Circuit Television (CCTV) and is designed for the short-term management of prisoners who have harmed themselves, or

[13] https://www.oics.wa.gov.au/wp-content/uploads/2016/12/Prison-Capacity-Review-Final.pdf

expressed intent to harm or kill themselves, or who need “time-out” for other reasons. Those at risk of harm are placed on the At-Risk Management System (ARMS). Placement in CCU is determined by the Prisoner Risk Assessment Group (PRAG).

The SHU consists of six cells intend to contain those who pose a major threat to the prison system, with strict entry criteria, management plans, weekly visits by senior prison staff, and monitoring by a committee. Three cells have monitored CCTV. The SHU is not intended to be punitive, however prisoners in the SHU aren’t always able to access the time out of their cells they’re entitled to and interaction with other prisoners is minimal. Expert opinion is that placement in the SHU increases the risk of suicide and irreversible psychological damage due to the isolation.

Suicide prevention training (‘Gatekeeper’ training), mental health awareness, and first aid courses are provided to prison staff, but these are not refreshed regularly. There is a Prisoner Risk Assessment Group which manages the At-Risk Management System (ARMS) and the Support and Monitoring System (SAMS). The ARMS is the primary suicide prevention strategy that provides staff with clear guidelines to assist with the identification and management of prisoners at risk of self-harm and/or suicide. When a prisoner is placed on ARMS because of a perceived increase in the risk of self-harm or suicide, monitoring of that risk usually requires some change to the prisoner’s routine. The SAMS is the secondary suicide measure that targets and supports prisoners deemed to be at a more immediate risk of suicide e.g. prisoners facing a long sentence, sex offenders, prisoners with past suicide or self-harm attempts, those with feelings of guilt or shame.

In 2015 social workers and counsellors at the major male maximum security facility worked in the Prison Counselling Service (PCS) and mental health staff worked in the Prison Health Service (PHS). They did not share mutual records. In May 2018 they merged to become the Health Service Directorate with shared records and policies.

Staffing numbers for PCS and PHS had been extremely low, even falling, resulting in high rates of burnout and staff turnover, staff working only in crisis mode, unable to provide any proactive or preventative counselling, with a lack of clinical supervision or debriefing. This was noted to have worsened with the budget cuts and recruitment freeze experienced around 2015.

Inquest findings and comments

The Coroner found that each case was suicide.

All five men had spent time in CCUs, either at the major male maximum security prison or in the prisons where they were originally received. One had spent 13 months in the SHU. Most of them had been under ARMS or SAMS at some point during their incarceration. Most of the men were known to have suffered adverse childhood events; some had experienced the deaths of relatives by suicide or natural means. Some were ‘out of country’. Several had voiced suicide intent or had made previous attempts. One was still on remand. There were extensive histories of drug use by some of the men and some were diagnosed as having antisocial personality disorder. Further details of their lives can be found in the inquest findings.

The Department of Justice made a number of changes to policies and procedures relating to risk assessment and monitoring of at-risk prisoners, staff training, plastic cutlery, monitoring of razor blades, increased capacity, ligature minimisation. There has been discussion around plans for a proposed 128 bed mental health subacute facility, and the staff that would be required to facilitate this.

Coroner's recommendations

The Coroner made eight recommendations relating to improving prisoner welfare and enhancing the security of the prison that were directed to the Department of Justice (the Department):

1. *The Department should take urgent steps to recruit additional Prison Counselling Service (PCS) and mental health staff for the Prison and more broadly, should consider the appropriate level of PCS and mental health staff for prisons across the State.*
2. *The Department should increase the number of three point and fully ligature-minimised cells available at the Prison without delay. Priority should be given to those cells routinely used to house vulnerable prisoners (e.g. the orientation cells in unit 5). In addition to increasing the number of ligature-minimised cells at Casuarina Prison, the Department should review whether the light fitting covers currently used in all cells at Casuarina Prison (and which are regarded as suitable for use in ligature-minimised cells) are fit for purpose.*
3. *In order to better manage prisoners and thereby enhance security at the Prison, the Department should, without delay, take all necessary steps to ensure that PCS and Prison Health Service staff have reciprocal access to prisoner information stored in the EcHO computer system and the PCS module of the Total Offender Management Solutions system respectively.*
4. *The Department should consider introducing a "triage" system into prisons where all prisoners who have a known history of self-harm and/or suicide attempts are reviewed by a mental health professional within 24 hours of being received into prison. Consideration should be given to the use of videoconferencing facilities for regional prisons where mental health staff are unavailable.*
5. *The Department should consult with an expert in the field of trauma informed custodial care (TICC) to determine a process for incorporating the principles of TICC into its management of prisoners at the Prison.*
6. *The Department should consult with an expert in the field of mental health with a view to providing training to all staff on the features of personality disorders and common mental disorders and strategies to more effectively manage prisoners with these conditions.*
7. *The Department should consider further enhancing its Gatekeeper training program to ensure that it is primarily focussed on risk in the custodial setting. Consideration should also be given to including additional guidance for relevant custodial staff (e.g. reception officers) on conducting self-harm and suicide risk assessments. Gatekeeper refresher training should be conducted for all staff on a regular basis.*
8. *The Department should consider amending Policy Directive 36 – Communication so that wherever practicable, there is a positive obligation on custodial staff to advise a prisoner when changes are made to that prisoner's Prison Telephone System account.*

WA health system action

Currently, WA is the only jurisdiction in Australia where custodial health services are the responsibility of, and delivered by, the department responsible for corrective services. A collaborative project was established by the Department of Justice, the Department of Health and the Mental Health Commission to examine and assess the responsibilities for provision of health services within the justice system. The recommendations from the project are being considered by Government.

The Department of Justice addressed each of the recommendations in their response to the recommendations as posted on the Office of State Coroner's website[14].

[14] https://www.coronerscourt.wa.gov.au/_files/inquest-2019/casuarina%20recommendation.pdf

Case 2

The deceased was on remand at a Women's Prison when she hung herself in 2015. She had been taken into custody for alcohol related offences, her first lengthy period of detention. Whilst in prison, she was referred for counselling sessions with a psychologist as well as psychiatric review and treatment for alcohol withdrawal. She made several self-harm attempts, mostly ingesting cleaning products.

It was noted that she had poor coping skills, severe depression, and her risk of suicide was likely to escalate if she was sentenced to imprisonment. Preferred options for management were to provide long term psychological therapy as part of an intensive and structured residential rehabilitation or an inpatient psychiatry program. Transfer to the State's only forensic mental health unit was considered, but deemed not to be safe or of therapeutic value, as it is overcrowded, has high turnover, and is mostly filled with male patients who have psychotic disorders and a history of violence and sexual offences. Female patients generally require 1:1 supervision at all times for their own safety.

She spent some time in the Crisis Care Unit (CCU), but like most prisoners, she found the CCU restrictive, isolating and punitive with time spent mostly alone in a cell, and limited opportunity for time outside or socialising. Access to the yard was dependent on staff being available to provide supervision, and smoking was no longer allowed due to new buildings having been constructed within 5 metres of the former secure smoking area. Her mood and behaviour deteriorated whilst in the CCU, and phased transition to the general unit was carried out.

Sentencing was adjourned twice whilst she was in prison due to delays in finalising psychiatry assessment reports, and a few days after the second adjournment, she hung herself, leaving notes to family members finalising her affairs and saying good-bye.

Inquest findings and comments

The cause of death was ligature compression of the neck (hanging), and the manner of death was found to be suicide.

In September 2018, a report from the Office of the Inspector of Custodial Services entitled "Prisoner access to secure mental health treatment"[15] was released. It noted that 61% of referrals for secure mental health treatment lapsed without placement. The true demand was undoubtedly much higher due to under-referring. Forensic mental health services in WA are significantly under-resourced compared with the rest of the country. The secure forensic mental health unit has only 30 beds and has not increased in capacity for over two decades, despite the trebling of the prison population and increase in mental health problems in prisoners.

The report recommended that the Government provide funding to increase the number of secure forensic mental health beds and support the establishment of a subacute unit in the women's prison. The proposal for the subacute unit was submitted for consideration in the State Government Budget May 2019 but not supported.

A privately-run Remand and Reintegration Facility opened in December 2016. Its stated philosophy is around taking the opportunity to link women with support that will strengthen their capacity to live stable and productive lives and reduce their likelihood of reoffending. It houses 256 women, but the majority of unwell prisoners remain at the women's prison. It was noted that court-ordered pre-sentence psychological and psychiatric reports are regarded as confidential, and thus not shared with prison clinicians who provide care and treatment.

[15] https://www.oics.wa.gov.au/reports/prisoner-access-to-secure-mental-health-treatment/

Coroner's recommendations

The Coroner made three recommendations:

1. *I recommend that the Government commit funding to the establishment of a subacute mental health unit in the Women's Prison, properly staffed with a multidisciplinary mental health team, as a matter of priority.*
2. *I recommend that the Government commit funding to establish a 'female only' secure forensic mental health unit as a matter of priority.*
3. *I recommend that the Honourable Attorney General give consideration to amending the Sentencing Act 1995 (WA) to permit the release of court ordered medical reports to the medical and nursing staff who are treating remand and sentenced prisoners in Western Australia to ensure that this valuable source of information is able to be accessed to improve the level of care and treatment that can be provided to prisoners.*

WA health system action

Of the three recommendations, the first and third were deemed out of scope for the WA health system. The second recommendation to commit funding to establish a 'female only' secure forensic mental health unit as a matter of priority was reviewed.

Advice was provided to the Minister for Mental Health on the feasibility of the recommendation. The establishment of appropriate infrastructure and forensic beds for vulnerable populations, including women and youth, is a priority for the Mental Health Commission (MHC). The MHC is working closely with the Department of Justice (DoJ) to progress any potential infrastructure that could be re-purposed for vulnerable populations, as a medium-term option.

As part of a DoJ-led submission, funding will be sought for community mental health services and additional psychiatric in-reach. Given the lack of forensic beds, the submission will include the need to develop an appropriate facility (and estimated capital and operational costs) to meet the increased demand on the forensic mental health system, directly associated with the implementation of the legislation.

The Coronial Review Committee supports the principle of providing gender-sensitive, trauma-informed care for females and other vulnerable groups within existing and new forensic inpatient units. New developments need to consider this requirement for vulnerable forensic patients.

Case 3

A 36-year-old man died in a regional prison.

Born into a large close-knit family, the deceased's parents separated when he was a child and his mother raised him and his six siblings. He self-reported an abusive childhood, and started using cannabis at age 11, followed by alcohol and amphetamines. He had extended contact with Mental Health and Drug Services, a Regional Aboriginal Medical Service, and a Men's Outreach Program. He had been diagnosed with Cluster B personality disorder, with polysubstance abuse resulting in episodes of drug induced psychosis and an increased risk of harm to self and others when unwell. He was prescribed medication to act as a mood stabiliser and anti-psychotic but did not engage in ongoing cognitive therapy. He had an extensive forensic history from childhood, with increasing violence when intoxicated, and there were a number of alerts for self-harming behaviours in the prison system.

The deceased had three children, and was working in the kitchen at TAFE, hoping to become an apprentice chef. When sober, he often spoke of wanting to improve his life for the sake of his children.

In 2015, he set fire to his bedroom at his mother's house, breaching a violence restraining order (VRO), and he gave various reasons as for his actions, including a failed attempt at self-harm. Following assessment and treatment for smoke inhalation at hospital he was released to police custody, charged with arson, and remanded at the regional prison for 11 days as his family and friends were unable to meet the initial bail requirements. He was not assessed as being at risk personally but, due to knowledge of the recent suicide of one of his brothers, he was placed on the at-risk management system (ARMS). He remained in custody for over a month until his bail conditions were reduced to a level that his family could meet. During this period, he was transferred between regional prisons, before returning to his own region. When informed of the impending transfer to another regional site he self-harmed.

After his release, he spent the next 5 months living with his mother, working at TAFE, and sought referral to Community Alcohol and Drug Service, but also began using drugs again, and at times was unpredictable, violent, or apparently responding to unseen stimuli.

He was taken to the local regional Magistrate's Court to appear by video-link to the Supreme Court. His uncle was unable to sign documents of surety as expected to allow for release on bail, as he was away at work. It was expected that the documents would be signed the following morning. The deceased appeared shocked and unprepared at the prospect of entering custody. He was taken initially to the Magistrate's Court custody centre holding cells where he disclosed his history of depression and self-harm, and that he had not taken his usual mood-stabiliser that day and had not brought it with him. He expressed frustration, said he wanted to go across the road (the prison was across the road) and banged his head against the wall. He was then transferred by van to the prison 500m away and initial reception and screening was conducted by prison staff as there were no health staff present at reception. The usual custody paperwork did not accompany him, nor was it uploaded to the prison information system. A few hours after entering prison, he was found hanging by his own shirt in the showers and resuscitation attempts were unsuccessful.

People who had been in contact with him during the course of the day (the Men's Outreach Centre member who accompanied him to court, another uncle who was the guard who transferred him from court to prison, prison staff, a Peer Support prisoner and an Aboriginal Visitor scheme staff member) had no concerns at any stage about any increased risk of suicidality.

Inquest findings and comments

The cause of death was found to be ligature compression of the neck (hanging); and the manner of death was suicide. The Coroner thought it was unlikely that the outcome would have been different even if information sharing and risk assessment had gone as planned.

The Coroner discussed briefly the problems faced by the whole community around how to keep people with personality disorders contained when they destabilise, in order to cause the least amount of harm; the need for custodial facilities to have good mental health resources and processes as well as good information sharing between all care providers including medical and custodial stating "confidentiality has no place when there is a duty of care to minimise risk".

Risk minimisation strategies in prisons such as ligature point reduction and the use of CCTV were also discussed, recognised as a 'band-aid solution' that do not promote wellbeing but may still be necessary given the high prevalence of impulsivity of people in prisons.

Coroner's recommendations

The Coroner made six recommendations directed to the Department of Justice:

1. *Retain and ensure the prison has appropriate services which acknowledge it is a major transition facility with all the known risks that transition raises.*
2. *Information sharing between medical, PCS and mental health services in prison and appropriate sharing of information between custodial facilities and organisations in the community caring for those with mental health issues.*
3. *Effective CCTV and practical ligature minimisation. I am not suggesting CCTV directly into toilet or shower facilities, but good coverage on adjacent points may avoid issues to do with welfare. It is a sad fact that rarely in inquests are all relevant CCTV monitors operational.*
4. *Prison officer training that those with prior suicide attempts are at elevated risk in custody regardless of their demeanour.*
5. *The promotion of active involvement of prisoners in caring for one another.*
6. *Realisation on behalf of custodial services that welfare and security go hand in hand. I appreciate that prisons are involved in security on behalf of the community, but destabilised prison populations due to successful suicides are distressing for all concerned, staff and other prisoners, and can rapidly become a security issue of itself.*

Suicide in immigration detention

The deceased was a Kurdish man from Iran who, due to his ethnicity, was considered stateless. He had no formal education and had experienced several significant stressors while living in Iran including homelessness, drug dependency, persecution due to his cultural heritage, and periods of imprisonment and torture. He arrived in Australia in October 2011 as an unauthorised migrant seeking protection as a refugee.

In March 2012, his status as a refugee was recognised and he was advised that consideration of his eligibility for an Australian visa would commence. However, this process was not completed by the time of his death in 2015. He was moved between multiple Immigration Detention Centres (IDCs) including Christmas Island, Curtin, Melbourne, Brisbane and Darwin, and was detained on Christmas Island at the time of his death.

Between June 2012 and April 2013, the deceased made several threats to kill himself. He was assessed by several clinicians as having exhausted his capacity to cope in the detention environment and was transferred to community detention in April 2013 where he reportedly did well. He was transferred back to secure detention in December 2013 following a conviction for assault, and his mental health subsequently deteriorated. He had multiple contacts with mental health services between 2013 and 2015 due to exhibiting several psychiatric symptoms including low mood, self-harm, suicidal ideation, possible psychotic symptoms and behavioural disturbances including climbing onto rooftops while in detention. Despite multiple assessments and a period of hospitalisation, his diagnosis remained unclear with possible diagnoses including brief psychotic episodes, major depression, adjustment disorder, anxiety with somatic symptoms and possible limited intellectual capacity.

The deceased was moved between several IDCs. It was discussed during inquest that individual clinicians provided high quality care, but frequent movement compromised continuity of care, and while detained at Christmas Island, psychiatrist input was limited to telehealth assessment.

Shortly before his death, the deceased escaped from Christmas Island IDC. His escape was not noticed despite perimeter alarms sounding due to inexperienced and untrained staff managing

the facility control room. However, due to the terrain surrounding the IDC, a search would not have been possible at night due to the level of risk to staff even if the escape had been noted at the time.

The deceased was subsequently found two days after his escape in the jungle close to his escape point with a ligature around his neck. However, the circumstances in which his body was found provided evidence for differing theories as to the manner of death including intentional and unintentional death.

Inquest findings and comments

The deceased died from ligature compression of the neck. An open finding was made as to the manner of death.

The Coroner found that the death would have been preventable if the deceased had remained inside the IDC, so his escape was a relevant issue, but that changes have occurred at Christmas Island IDC since his death which mitigate this risk.

The Coroner accepted that the deceased's mental health diagnosis was uncertain and multifactorial, but that continued detention adversely affected his mental health. While the individual care provided by clinicians was found to be of a good standard, the lack of continuity of care due to frequent movement and the absence of in-person psychiatric review at Christmas Island were identified as deficits.

Coroner's recommendations

The Coroner made two recommendations for the Department of Immigration and Border Protection and International Health and Medical Services (IHMS) regarding provision of mental health care.

1. *I recommend that the Department/Commonwealth should work together with IHMS to ensure that a psychiatrist is available to provide in-person psychiatric assessments at Christmas Island for detainees at least on a fortnightly basis, acknowledging the practicalities of limited flight services to the island.*
2. *I recommend that the Department/Commonwealth should work together with IHMS to make it a contractual requirement with IHMS that there be an increase in the number of mental health clinicians at Christmas Island than was the case at the time of (this event), so that there is a reduced delay between requests for medical attention and appointments. Clinical governance of the provision of mental health services by the mental health team should also be supervised by a psychiatrist.*

References

- 5 Deaths in Casuarina Prison findings[16]
- Department of Justice response to recommendations from 5 Deaths in Casuarina Prison[17]
- NICOL findings[18]
- JACKAMARRA findings[19]
- CHEGENI NEJAD findings[20]
- Western Australia's Prison Capacity Report 2016[21]
- Review of prisoner access to secure mental health treatment 2018[22]
- Department of Justice response to review of prisoner access to secure mental health treatment[23]

Further reading and resources

- Australian Institute of Health and Welfare – Overview of health of prisoners[24]
- Office of the Inspector of Custodial Services: Custodial environment pressures[25]

Discussion points

- The responsibility for care of people in detention is shared between multiple government departments and services at different times. How can continuity of care and sharing of information be improved under these circumstances? What role does clinical handover play?
- Healthcare workers are often faced with having to discharge patients back to the same situation that had contributed to their poor mental or physical health. How can we advocate for our patients' safety under those circumstances? What role do dedicated advocacy services play?

[16] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_deaths_of_mervyn_kenneth_douglas_bell.aspx
[17] https://www.coronerscourt.wa.gov.au/_files/inquest-2019/casuarina%20recommendation.pdf
[18] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_annabel_nicol.aspx
[19] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_khamsani_victor_jackamarra_also_known_as_hajinoor.aspx
[20] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_fazel_chegeni_nejad.aspx
[21] https://www.oics.wa.gov.au/wp-content/uploads/2016/12/Prison-Capacity-Review-Final.pdf
[22] https://www.oics.wa.gov.au/reports/prisoner-access-to-secure-mental-health-treatment/
[23] https://www.oics.wa.gov.au/wp-content/uploads/2018/11/2018-DOJ-Mental-Health-response-recommendations-only.pdf
[24] https://www.aihw.gov.au/reports-data/population-groups/prisoners/overview
[25] https://www.oics.wa.gov.au/about-oics/custodial-environment-2016-2017/

Suicides in community

Key Messages

- Patients may experience an elevated risk of suicide following discharge from an inpatient setting. Careful discharge planning and continuity of care for patients returning to the community is of critical importance
- Mental health care systems are complex and can be difficult to access and navigate for patients and staff

Case 1

A 31-year-old woman died at home as a result of incised wounds to the neck and arms after being discharged from hospital without full psychiatric assessment.

The deceased had no previous mental health problems. She had a congenital endocrine expression condition that was stable and well-managed medically and lived with her parents. A few weeks before her death her family noticed an abrupt change in her demeanour, sleeping less, being more dependent than usual on her family for company, complaining of headaches and a fear that she was developing motor neuron disease or another neurological condition.

One night she went to an emergency department and spoke with the triage nurse, saying she wanted to speak with her endocrinologist as she felt her usual medications were no longer working. She did not disclose any thoughts of suicide, and did not wait to see a doctor, but left and went to the beach where she considered drowning herself. The triage nurse, concerned about the deceased after she left without waiting, rang her family to check if she had arrived home safely, and so the deceased's parents were able to contact her and ask her to come home.

The following day her parents drove her to her endocrinologist's office at her request, where she was able to speak with the endocrinologist by phone. The deceased was assured that the symptoms she was experiencing were unrelated to her medication, and she was advised to see her general practitioner (GP) for referral for mental health support.

She saw her GP that morning, who helped her make an appointment to see a psychologist five days later. Distressed at having to wait so long to be seen, she asked her father to kill her. Staff at the GP practice referred her to hospital, placing a call through to the emergency department consultant and organising an ambulance for transfer.

The deceased was seen in the emergency department by a junior medical officer who attempted to organise psychiatric review. The psychiatric liaison nurse on duty had been called away, and the next one rostered was not available for several hours. The psychiatric registrar on duty at the hospital's mental health clinic advised that the deceased should wait to be seen in the emergency department, but the busy and noisy environment caused her to become increasingly distressed.

Further contact with the clinic was made, and conflicting reports regarding the subsequent conversations and advice given were presented at the inquest. The psychiatry registrar stated that he advised she should be seen on an outpatient basis, but she could bring the referral from the GP to the clinic that evening if she liked. The junior medical officer in the emergency department believed that she was to go to the clinic for full assessment that evening. The triage nurse at the clinic was unaware of the history behind the deceased's presentation and was

distracted by the fact that she came from a suburb outside of the clinic's catchment area and should be seen at a different clinic.

The deceased did not undergo assessment at the clinic, went home with her parents, and killed herself in her room later that night.

Inquest findings and comments

The manner of death was found to be suicide. The Coroner highlighted the lack of resources put towards mental health treatment in Western Australia translating to a lack of inpatient mental health beds, a lack of properly trained and available psychiatrists and mental health professionals, and a lack of appropriate areas in which to assess an increasing number of patients.

Coroner's recommendations

The Coroner made one recommendation:

1. *I recommend the Honourable Minister for Health give priority to commissioning a Mental Health Observation Area at the Hospital's Emergency Department.*

The Coroner also urged *those reviewing the mental health service provided at public hospitals to focus on ways of ensuring mental health emergencies are treated as seriously as any other medical emergency, with appropriate resources directed to ensuring that they are treated by properly trained staff in therapeutic environments*.

WA health system action

While the relevant Health Service Provider does not have a MHOA, the hospital has an 8 bed Mental Health Assessment unit (MHA) located in the Mental Health building and connected to the emergency department. The MHA allows for an extended assessment period in a therapeutic environment and, unlike a MHOA, accepts admissions for both voluntary and involuntary patients and those at high risk.

Case 2

A 30-year-old man died after he hung himself less than a fortnight after being discharged from a mental health unit.

The deceased had a background of chronic major depression with anxiety and was living with his supportive family. In the last five years of his life, he had contact with counselling services at the university where he was studying, his general practitioner (GP), a community psychologist and a psychiatrist, and had several admissions to the Mental Health Unit near his home.

Stress over university exams and a relationship break-up resulted in an exacerbation of depression with increased attempts at self-harm by placing ligatures around his neck. He was referred to hospital by his GP for review, and voluntary admission to a mental health unit was agreed upon.

Unfortunately, the mental health unit that he had spent time in previously was full, and to avoid a prolonged stay in the emergency department, admission to hospital in a different Health Service Provider was arranged and he was transferred the following evening. As he had not stayed in this unit before, he and the staff were unfamiliar to each other.

During the 18-day admission, no family meeting was held despite his parents' requests for one, their daily presence on the ward and extensive involvement in the deceased's care. It was documented that consent was given for collateral history to be obtained from family five days after

admission. No rationale for not holding a family meeting was documented. The deceased was discharged home shortly after undergoing a change in medication. No formal follow-up in the community was arranged for him.

He completed suicide at his home. Resuscitation attempts were unsuccessful.

Inquest findings and comments

At inquest 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 the deceased's alleged requests not to involve his family in his care, the inadequacy of discharge planning and failure to arrange follow-up.

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) until they were notified about the initiation of the inquest.

Coroner's recommendations

The Coroner made six recommendations:

1. *The HSP consider amending its Care Coordination in Mental Health policy to include a requirement that prior to discharge, mental health consumers are handed a card showing the date and time of all of the appointments that have been arranged with the services they have been referred to.*
2. *The HSP consider amending its Care Coordination in Mental Health policy to include a requirement that all discharge summaries issued to mental health consumers must contain: contact details of emergency services; out of hours contact numbers and other support services including the Mental Health Emergency Response Line; details of the appointments made with any service or agency the patient is being referred to (this is in addition to, not in lieu of the appointment card referred to in Recommendation 1); information on the process of re-entry to the HSP (or other relevant health service) if needed; and the name of the mental health consumer's clinician or care coordinator.*
3. *The HSP consider amending its discharge procedure so that, except in exceptional circumstances, it is not possible to print off a mental health consumer's discharge summary, or to discharge that consumer until appointments have been made and an appropriate handover of information has occurred, with all of the services that the consumer is being referred to on discharge.*
4. *The HSP consider developing strategies to ensure that clinical and non-clinical staff are familiar with key policies. Those strategies might include handing new staff a list of the top 10 policies they should be aware of and discussing key policies (including any changes) at regular team meetings.*
5. *The HSP examine the feasibility of establishing a post discharge follow-up team, especially with respect to 'out of area' admissions, to bridge the gap between the point when a mental health consumer is discharged from an inpatient service and the point when that consumer is accepted by the receiving service.*
6. *The Office of the Chief Psychiatrist consider issuing guidelines as to what communications can be had with a mental health consumer's family or support person in circumstances where a competent and voluntary consumer refuses to have their family or support person involved in their care. Consideration should also be given to issuing an abridged version of any guidelines that re published, as a practice note.*

WA Health system action

The first five recommendations were directed at the HSP and the last recommendation was deemed out of scope by the Coronial Review Committee.

The HSP has established a Care Coordination Working Group to revise the current Care Coordination in Mental Health Policy to address a number of the recommendations. The HSP has also undertaken significant work with discharge summary compliance and with respect to ensuring staff are familiar with the key policies, a Mental Health Quality Improvement Program is underway to establish and review policy awareness processes at orientation as well as at an ongoing nature.

References

- TREGONNING inquest findings[26]
- STRANGE inquest findings[27]
- WA Clinical Handover Policy[28]

Discussion points

- What follow-up do your patients require after discharge from your service? How does your service ensure this is provided?
- In what circumstance might patients miss out on planned follow-up and how can this be avoided?
- How can we make it easier for patients to access the care that they need?

[26] https://www.coronerscourt.wa.gov.au/l/inquest_into_the_death_of_melanie_reanna_tregonning.aspx
[27] https://www.coronerscourt.wa.gov.au/l/inquest_into_the_death_of_paul_strange.aspx
[28] https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Clinical-Handover-Policy

Unexpected deaths in mental health units

Key Messages

- The combination of chronic health conditions, acute illness and medications required for treatment of acute psychiatric deterioration may contribute to adverse outcomes
- Monitoring vital signs after sedation may aid in the detection of clinical deterioration

Case 1

A 64-year-old woman died at in a mental health unit from a cardiac arrythmia.

The deceased had a background of bipolar affective disorder with multiple prior involuntary admissions. She was obese and had obstructive sleep apnoea (OSA) requiring continuous positive airway pressure (CPAP) at night.

The deceased was brought to hospital because of her deteriorating mental health. She was assessed as needing admission to a secure ward, however none were available, so she remained in the emergency department (ED) where she received sedation as she was distressed and walking around the ED incessantly. Her initial physical examination was unremarkable.

Overnight her oxygen saturation dropped whilst she was sedated, requiring supplemental oxygen. On waking later that morning she subsequently did not allow vital signs to be measured. As there was still no bed available on a secure unit, and she was increasingly agitated and difficult to contain in the ED, it was agreed that she would be admitted to an open ward instead. She was transferred to the Older Adult Mental Health Service ward in the afternoon. No mention was made at handover of the period of desaturation whilst sedated, however these were documented in her notes, which were reviewed by the psychiatry registrar on the ward. She refused physical assessment and paced around the ward whilst draped in a white sheet, which covered her face and which she tripped over several times.

At around 3pm it was decided that she was to be sedated to allow for adequate care including protection from injury. The ward pharmacist had performed medication reconciliation by this stage and discussed the risks of respiratory depression in a patient with OSA, the need to avoid co-administration of a benzodiazepine, and the need for monitoring. As the deceased refused oral medication, she had to be physically restrained in order for intramuscular olanzapine to be administered, and staff noted she stopped struggling shortly before the injection was given. No specific orders regarding observations were given, and the general understanding of the nursing staff was that visual observation of respiratory rate was required every 15-30 minutes, but other vital signs could be postponed until she was adequately settled.

A number of visual observations were conducted between 3:15pm and 4:05pm when it was noted that she was breathing but had rolled on to her stomach with her face turned to one side. Approximately 10 – 15 minutes later, the nurse and a student nurse entered the room to conduct a full set of observations and noted that her face was now turned into the pillows, and she was unresponsive, with blue lips. Resuscitation attempts by the medical emergency team were unsuccessful.

Inquest findings and comments

The cause of death was determined to be a fatal cardiac arrhythmia in a woman with obstructive sleep apnoea and suffering an acute psychotic episode requiring sedation. The manner of death was natural causes.

Expert witnesses testified that there was no evidence of QT prolongation on previous electrocardiograms (ECG), and the level of olanzapine in the deceased's blood was very low and would not have caused sedation that would have contributed to the death. There was no evidence of hypoxia or hypoventilation on a blood gas taken during the resuscitation, but it was noted that people with OSA have an increased frequency of sudden death, probably due to arrhythmia.

The Coroner referenced another inquest, finding that the level of sedation was not related to their deaths but the levels of arousal, in conjunction with known clinically high-risk factors such as body habitus, diabetes and especially sleep apnoea, were considered relevant to the overall circumstances related to their deaths.

The Coroner was satisfied that the deceased was managed on the ward as well as was possible, given the available resources.

Expert opinion was given that there are difficulties with the current mental health system which made it impossible for mental health facilities to properly care for acutely unwell mental health patients. Highly aroused patients have to be treated but the environment in a dedicated psychiatric facility is not protective of their clinical state, while an ED or acute setting is not therapeutic for their mental state. Mental health observation units were discussed as being an ideal model.

Coroner's recommendations

The Coroner made one recommendation:

1. *I recommend the provision of mental health observation units attached to EDs, intensive care units, high dependency units in all hospitals which also have mental health facilities to allow appropriate transition of mental health patients, with high clinical risk factors for sudden death, from acute areas to general mental health facilities.*

WA health system action

The Coronial Review Committee reviewed information about the current practice, use and appropriate staffing levels of mental health observation areas (MHOAs) across Health Service Providers (HSPs).

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

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

Case 2

A 40-year-old man died in a mental health unit many hours after receiving sedative medications.

The deceased had been diagnosed with a psychotic disorder in his early 20s, variously described as chronic paranoid schizophrenia or bipolar affective disorder. He required multiple involuntary admissions to mental health facilities during his life, and was often aggressive and difficult to manage, and once seriously assaulted another patient.

His medical history included type II diabetes, hypertension, hypothyroidism, and suspected obstructive sleep apnoea. He had a high body mass index (BMI) and was a heavy smoker. During one admission to hospital he was noted to be having multiple apnoeic episodes while sleeping, and at one stage had blood tests suggestive of sleep hypoventilation. There is no record of any formal investigation of sleep apnoea, and he did not have a continuous positive airway pressure (CPAP) machine. The last electrocardiogram (ECG) recorded was many years before his death.

He required admission to a mental health unit when he suffered from a relapse after his father was diagnosed with cancer. During his admission he refused investigation for his diabetes, was resistant to examination, and at times refused his regular medications. He was often abusive and threatening to staff and other patients, and security staff were required at times. Periods of agitation were treated with quetiapine, haloperidol, clonazepam, sometimes in combination. A large number (24) of doses of sedative medication for agitation were administered during this admission with no adverse effects noted.

Around two months later, he was discharged to the care of his parents. The community mental health service was not involved in discharge planning and did not receive any referral or handover of care. The service became involved when the deceased presented to them asking for assistance in finding independent accommodation. Over the following week the deceased deteriorated and required involuntary readmission to the mental health unit.

The admitting registrar could not find the recent discharge summary in the files. Full physical examination was postponed to the following day due to the deceased's lack of cooperation. He was given haloperidol and clonazepam and settled and appeared to be asleep an hour later. Visual observations including respiratory rate were conducted during the night as he was seen to be sleeping, sometimes snoring, up to 6:30am. At 7am he was noted to be unrouseable, and resuscitation efforts were unsuccessful.

Inquest findings and comments

The cause of death was determined to be consistent with cardiomyopathy with early pneumonia in a man with reported sleep apnoea and a high BMI, due to natural causes. Drugs with sedating or respiratory depressant effects were not detected in the toxicology screen, due to being present only in immeasurably small amounts.

The Coroner heard from expert witnesses who raised concern about the level of care required for patients who require sedation, especially those with comorbidities that may predispose them to cardiorespiratory arrest or sudden death. Continuous oxygen monitoring, 1:1 care, and management in high dependency units (HDUs) or intensive care units (ICUs) were discussed, as well as the need for good management of medical comorbidities.

The Coroner was of the opinion that the supervision, treatment and care of the deceased in this case was reasonable but expressed concerns regarding a lack of prior investigation of cardiac and respiratory conditions and being in a facility that did not have extensive monitoring.

Coroner's recommendations

The Coroner made four recommendations:

1. *Compliance with proper discharge planning between all facilities dealing with patients with mental health issues.*
2. *Emphasis on clinical medical health issues for those suffering mental health conditions while in the community so risk factors when inpatients are properly appreciated.*
3. *Consideration and documentation of the benefits, or otherwise, of oxymetric observations of sedated mental health patients with other risk factors for respiratory arrest, especially sleep apnoea, where visual observations may not detect hypoventilation.*
4. *More availability of appropriate acute facilities for highly aroused mental health patients at times of essential sedation.*

WA health system action

The psychiatric hospital has implemented or updated a number of policies related to sedation, physical health care and discharge since the death.

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

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

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

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

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

Case 3

A 30-year-old man died of methadone toxicity and respiratory depression whilst in a mental health unit as an involuntary patient under the Mental Health Act.

The deceased had been involved with mental health services since childhood and was diagnosed with paranoid schizophrenia in his 20s and treated with depot medication. He was obese, with attention deficit hyperactivity disorder (ADHD) and narcolepsy, achalasia, and chronic pain. He was commenced on methadone by a pain specialist three years prior to his death, and the dose had increased to 80mg over that time. He had two unintentional methadone overdoses, and his family were concerned he wasn't always taking his medications as prescribed.

He was admitted to hospital as an involuntary patient with a diagnosis of a manic episode of schizoaffective disorder after behaving unusually at his general practitioner's clinic. No beds were available on the closed ward, so after a night under guard in the emergency department, he was admitted to the open ward with 15 minutely visual observations ordered. His physical examination on admission was cut short due to his agitation. His electrocardiogram (ECG) showed a normal QT interval. Blood tests were not completed.

His ADHD medication was ceased due to concerns over potential impact on psychosis, and diazepam, codeine and methadone were continued. His long-acting depot was changed to a short-acting depot. He received 3 doses of this sedating antipsychotic during his admission. There was no policy regarding observations after administration at that time and only 8 sets of observations were recorded for the week of his admission.

During his admission he remained agitated and deluded, with varying levels of sedation. His family expressed concern about his level of sedation to the nursing staff on several occasions but this was not documented or escalated to medical staff.

In the afternoon before his death he was given olanzapine and clonazepam for agitation. Nursing staff recorded that he was asleep overnight, having asked for a blanket at 12:45am and been heard to snore at 3am. At 7:55am he was discovered to be deceased, with obvious rigor mortis so no resuscitation attempts were made.

Inquest findings and comments

The Coroner made an open finding with respect to the deceased's death, noting a high blood level of methadone, and therapeutic levels of other psychotropic drugs which have respiratory depression and arrhythmia as potential side effects.

The Coroner identified two broad areas where care and treatment could have been improved.

- Monitoring of vital signs – more regular checks may have provided an opportunity to identify any deterioration however the Coroner acknowledged that more frequent monitoring is disruptive and compromises the benefit of sedation, and felt that as a one-size-fits-all approach would obviously be inappropriate, the emphasis must be on the clinical judgement of staff.
- Risk of absconding and 15 minutely checks – it was discussed that the usual practice on the ward for night checks was to shine a torch through the door rather than entering the room to minimise sleep disturbance, and there were no expectations that signs of life would be checked. Staff expressed different views as to what was required for 15 minutely checks in general.

Coroner's recommendations

The Coroner made three recommendations:

1. *The Hospital's safe and supportive observation charts (the charts) should be amended to make it clear that as required by the policy "Observations: Safe and Supportive", when a patient appears to be asleep, respiration rates must be recorded on the relevant chart and further, a column should be included on the charts for that purpose.*
2. *When visual observations are ordered by medical staff or where the frequency of those observations is increased by nursing staff, the reason for the order (or the change in frequency observations) should be documented in the patient's progress notes and on the patient's safe and supportive observation charts. A notation that merely indicates the frequency at which observations are to be made should not be regarded as sufficient.*
3. *The Hospital's zuclopenthixol acetate chart should be amended to make it clear that the vital signs observations prescribed by the Zuclopenthixol Acetate (Clopixol Acuphase) Guidelines must be recorded on the patient's adult observation and response chart, and nowhere else.*

WA health system actions

The recommendations were reviewed and the changes were extended to all mental health services within the Health Service Provider's (HSP) remit. The suggested changes to the documentation used to record observations of mental health patients when asleep and/or given sedating medications have been implemented. The revised charts have been accompanied by revised processes, policy and awareness raising with staff. Auditing is now underway to ensure the ongoing effectiveness of the changes.

Compulsory annual training was introduced for clinical staff covering sedating medications and the importance of monitoring sedated patients, identifying and responding to clinical deterioration. More frequent oxygen saturation monitoring was recommended, and a pulse oximeter was purchased. New policies were introduced relating to the prescription of medications and the monitoring of patients with schizophrenia, and around safe and supportive observation of patients.

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

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

Case 4

A 46-year-old man died as a result of cardiac arrhythmia on the background of significant pre-existing heart disease. He was an involuntary patient under the Mental Health Act at the time, suffering a relapse of bipolar affective disorder with psychotic features.

The deceased had a background of metabolic syndrome, including obesity, hypertension, Type 2 diabetes and raised cholesterol. He'd received medications and advice on lifestyle modification given his increased risk of cardiovascular disease, however he continued to smoke heavily. Medical examination and electrocardiograms (ECGs) on admission and the day before his death revealed no obvious cardiac abnormalities.

He had previously threatened to burn down the ward if admitted as an involuntary patient due to not being allowed to smoke whilst on the locked ward. Despite being offered nicotine replacement therapy, he became agitated and aggressive to staff. Intramuscular clonazepam was administered without effect, then he was placed in seclusion for several hours.

When he agreed to take oral medications (promethazine, chloral hydrate) he was allowed to return to his bedroom for the night. Half hourly visual observations were conducted and he was noted to settle and sleep, and was seen snoring at 06:30 the next morning. 15 minutes later when staff attempted to rouse him, he was unresponsive. Resuscitation attempts were unsuccessful.

Inquest findings and comments

The cause of death was found to be a cardiac arrhythmia with significant pre-existing heart disease, with the presence of myocarditis, heart muscle hypertrophy and scarring, due to natural causes.

Management of cardiac risk was discussed. The deceased had multiple risk factors including taking psychotropic medications, but had no clinically apparent cardiovascular disease. Expert cardiology opinion was that stressful situations can increase the risk of a cardiac event. Psychiatric opinion was that the care provided was appropriate, albeit undoubtedly stressful.

Access to smoking areas was discussed. WA hospitals are smoke free under state wide policy. The hospital to which the deceased had been admitted does not provide a secure smoking area for involuntary patients; nicotine replacement therapy is provided and is adequate for and accepted by most patients. The Coroner did not pursue this issue further.

The Health Service Provider's (HSP) seclusion policy was reviewed. It does not include requirements for physical monitoring other than visual observations through a window. Expert opinion was that pulse oximetry would be a useful safety measure in situations requiring rapid tranquilisation, and that this is being used more widely in psychiatric units than before.

Coroner's recommendations

The Coroner made one recommendation:

1. *I recommend that the WA Department of Health give consideration to utilising pulse oximetry in mental health patients who have been agitated and required significant sedation, for a suitable period of observation, to ensure that any monitoring is capable of identifying where a patient is exhibiting a decrease in oxygen saturation that may indicate they are experiencing a cardiac event.*

WA health system actions

The Coronial Review Committee (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, increased 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.

References

- ASHLEY findings[29]
- DEBNAM findings[30]
- O'NEILL findings[31]
- MALLETT findings

Further resources

- Mental Health Emergency Response Line (MHERL)[32]
- WA Medication reconciliation audit tool[33]
- WA Clinical Handover Policy[34]

Discussion points

- The Coroner recommended the provision of mental health observation units (MHOUs).
  - Does your site have an MHOU or equivalent?
  - What role does the MHOU serve?
  - If there is no MHOU, would your service benefit from one?
  - What are the barriers to developing one?
- How does your service or site ensure that people taking medication for psychiatric illness long-term have appropriate physical health assessments?
- These cases involve complications following sedation/chemical restraint.
  - What medications does your service use?
  - What post procedural care is given? Do you have a policy or guidance to refer to?

[29] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_pamela_edith_ashley.aspx
[30] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_christopher_john_debnam.aspx
[31] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_seanpol_martin_padraig_o_neill.aspx
[32] https://www.mhc.wa.gov.au/getting-help/helplines/mental-health-response-line/
[33] https://ww2.health.wa.gov.au/Articles/J_M/Medication-reconciliation
[34] https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Clinical-Handover-Policy

Opioids

Key Message

- Opioid dependence and addiction can arise from even short-term use, and they should be prescribed with caution
- Harm minimisation strategies can reduce morbidity and mortality from drug misuse

Case 1

A 24-year-old man died of opioid toxicity.

Whilst on army deployment overseas, he injured his ankle and hip whilst training at a gym. He was supplied with oxycodone at an American military hospital. He also developed post-traumatic stress disorder (PTSD) following his deployment. On his return to his home in the Eastern States he continued to take increasing amounts of oxycodone and benzodiazepines for hip and back pain. He forged prescriptions and was treated with naloxone in hospital three times in four months following overdoses. He was reported to the state's Doctor Shoppers Hotline.

Following discharge from the Army he moved to Perth to live with his family. The Australian Defence Force (ADF) provided him with a Clinical Summary, which he altered before giving it to his new general practitioner (GP) in Perth, removing all reference to substance misuse.

Over the next 6 months he visited multiple GP practices in Perth, obtaining tramadol and oxycodone. He was treated for overdose multiple times, including whilst an inpatient on a mental health unit. Some GPs and his treating psychiatrist attempted to obtain medical records from the ADF but with limited success. He was commenced on methadone and clonazepam at a pain clinic and was required to have daily dispensing due to episodes of substance misuse.

One GP called the Schedule 8 Prescriber Information Service, but the deceased was not registered. Another GP called the Repatriation Schedule of Pharmaceutical Benefits (RPBS) and found he'd had 190 oxycodone tablets dispensed in the previous 3 weeks. The final GP he saw did not contact any prescription monitoring services and prescribed high doses of oxycodone based on the history he provided.

The following evening, he went to bed with what appeared to be a cold and was found unresponsive the next morning. Resuscitation was unsuccessful.

Six weeks later, the GP who saw him the day before he died received a letter notifying her that the deceased was a notified drug addict who should not receive Schedule 8 medications.

Inquest findings and comments

At post-mortem, multiple transdermal patches and undigested tablets were noted, and the manner of death determined to be by way of accident.

The inquest focused on the lack of a real-time prescription and dispensing monitoring system for Schedule 8 drugs in WA. The Commonwealth has developed a system for Electronic Recording and Reporting of Controlled Drugs (ERRCD) but states have been developing their own systems

independently. A budget to develop a modified ERRCD was provided to the Western Australian Department of Health in 2016, however this is not yet operational.

The Schedule 8 Medicines Prescribing Code was discussed. It was implemented in 2014 and updated in 2017 to advise that Schedule 8 drugs should not be prescribed to a new or unknown patient without contacting the Schedule 8 Prescriber Service and updated once more in 2018 to promote the use of tapentadol over conventional opioids. The wording of the Code was discussed, with the Coroner expressing a preference for amendment to create a requirement for prescribers to contact the Schedule 8 Prescriber Service.

The difficulty medical practitioners face in obtaining ADF records for their patients was discussed. The Department of Defence do not routinely share medical records with the Department of Veterans Affairs. Records requested from the Department of Defence can take months to be provided, whether made by health professional or a patient under Freedom of Information (FOI).

Coroner's recommendations

The Coroner made one recommendation:

1. *That the Western Australian Department of Health liaise with the Department of Defence to consider and, if appropriate, implement a procedure to allow for the timely transfer of medical records of ADF members and veterans to treating medical professionals in Western Australia.*

WA health system action

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, acknowledged the issues highlighted in the coronial inquest findings and the relevance of the Australian Digital Strategy in facilitating a platform to share health information and committed to discuss options for sharing Defence health information with the Minister for Defence.

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 remains scheduled to occur in 2020.

With respect to the doctor-shopping of prescription drugs, the Coronial Review Committee 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 the 2020/21 financial year. RACGP is 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 in 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.

Case 2

A 25-year-old woman died from complications of opioid toxicity.

The deceased had started using oxycodone and heroin in her early twenties but had been largely abstinent for six months prior to her death with the support of a drug and alcohol treatment service.

One evening she attended a friend's house and used intravenous methadone with him. She went to work the next day, and returned to his house the next evening where she had another two injections of methadone. The following morning, she appeared to be still asleep or comatose, so her friend placed a part of a suboxone wafer under her tongue with the intention that the naloxone it contained would counteract the methadone and wake her up. He was concerned that his mother might discover the deceased was using drugs so did not call for an ambulance, instead asking his mother's friend who was at the house to check on her later. He then left with his mother to go to a drug rehabilitation appointment.

When checked upon, the deceased was unrousable and paramedics were unsuccessful in their resuscitation attempts when they arrived soon after.

Inquest findings and comments

The Coroner found that death occurred by way of accident from complications of opioid toxicity. Very high levels of methadone and buprenorphine were detected in the deceased's blood, along with low naloxone levels.

The deceased's friend was charged with Misuse of Drugs and sentenced to two years in prison. The Coroner did not find sufficient evidence that an indictable offense had been committed.

At the inquest the deceased's mother presented the Coroner with a number of suggestions on ways to reduce the number of deaths from drug overdose including:

- Medically supervised injecting centres.
- State funded emergency ambulances or assisted ambulance cover for private health or subsidised ambulance service.
- Evidence based drug policies rather than the legal enforcement of drug abstinence (such as in Switzerland and Portugal). The Coroner noted the National Drug Strategy 2017 – 2026 as evidence that such an approach is currently in place.
- Greater funding for take-home naloxone and for further public education programs to see it gets into the hands of those who need it most. Coroner noted that this seemed to be a sensible suggestion which warrants consideration by the Health Department if it has not done so already.
- Work to reduce the demonisation of drug use and the resulting stigma.
- Law reform to extend Good Samaritan laws to protect those who call for assistance in the case of overdose, a review of duty to care laws, and the creation of a duty to rescue law.

Coroner's recommendations

The Coroner did not feel that there was sufficient evidence adduced at the inquest to allow any recommendations to be made, noting that a coroner's powers to make comments or recommendations in relation to matters of public health is limited by the requirement that the matters are connected to the death in question.

WA health system action

The Coronial Review Committee reviewed the case in light of background information about the Portugal drug decrimalisation program and compared the socio-economic and environmental conditions in Australia. The rate of opioid-induced overdose in Australia continues to increase and pharmaceutical opioids are present in over 70% of opioid-induced deaths and the majority of these deaths are accidental. In 2018, people living in regional Western Australia had the highest rate of pharmaceutical opioid-related overdose fatalities in the nation.[35]

Regarding the suggestion from the Coroner for the Health Department to increase funding for naloxone and public education around its use, clinical experts reported that naloxone is now available more widely.

A trial at Royal Perth Hospital is underway to provide naloxone for all opioid overdoses. It is given either intramuscularly or intranasally. This is being funded by the Department of Health. Royal Perth Hospital is working with the Mental Health Commission to roll this trial out to relevant user groups. The support person is given assistance and information to administer it to the patient for opioid overdoses.

References

- TONKIN findings[36]
- HARE findings[37]
- The Schedule 8 Medicines Prescribing Code[38]
- The Pharmaceutical Benefits Scheme contacts for Health Professionals[39]
- National Drug Strategy 2017-2026[40]

Further reading and resources

- Australia's National Digital Health Strategy[41]
- Choosing wisely, recommendations from the Faculty of Pain Medicine on chronic pain[42]
- Recommendations for prescribing analgesia on discharge following surgery or acute injury[43]
- NPS MedicineWise: Opioids, chronic pain and the bigger picture information[44]

[35] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2018~Main%20Features~Opioid-induced%20deaths%20in%20Australia~10000
[36] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_matthew_neil_hardy_tonkin.aspx
[37] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_ellie_marlene_hare.aspx
[38] https://ww2.health.wa.gov.au/Articles/N_R/Opioids-benzodiazepines-and-other-S8-medicines
[39] https://www.pbs.gov.au/info/contacts/healthpro
[40] https://www.health.gov.au/resources/collections/national-drug-strategy
[41] https://conversation.digitalhealth.gov.au/australias-national-digital-health-strategy
[42] https://www.choosingwisely.org.au/recommendations/fpm1
[43] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/WATAG/Analgesia-Discharge-After-Surgery-or-Injury.pdf
[44] https://www.nps.org.au/professionals/opioids-chronic-pain

Discussion points

- What resources currently exist to help you find out what medications your patient has been prescribed?
- The Coroner referred to the National Drug Strategy, and noted that it incorporates evidence-based policies and practices.
    - What evidence is there that evidence-based approaches are being implemented?
    - What impact are they having?
    - What barriers exist to implementation of other strategies, policies and practices?
- Mental health, alcohol and drug, and community social support services often operate in silos. How can we better integrate these services to provide more holistic patient care?

Chest compression devices

Key Message

- Rates of chronic disease are elevated in the prison population, leading to increased demand on the limited healthcare resources of the prison system

A 44-year-old woman died from acute myocardial infarction whilst in prison on remand.

The deceased's cardiovascular risk factors included smoking, obesity, hypertension and amphetamine use. She took medications for blood pressure whilst in prison but not whilst she was in the community. An abnormal lipid profile had been detected a few weeks before her death but was not directly addressed with the deceased as she did not attend follow-up appointments with the prison medical service. She had never reported chest pain or been diagnosed with ischaemic heart disease prior to her death.

When she developed chest pain, after an initial delay in calling for assistance, the deceased was taken to the medical centre and given aspirin and oxygen. Glyceryl trinitrate spray (GTN) could not be administered by the nurse without medical authorisation. An electrocardiogram (ECG) was obtained and an ambulance requested, after an initial email was sent to the prison doctor asking for permission to do so.

Paramedics sent their ECG recording to headquarters via the ambulance phone, from where it would be faxed through to the hospital for review by cardiology. The initial attempt failed, leading to a short delay while it was re-sent. The Coroner expressed surprise over the standard pathway to send ECGs for review.

The paramedics were instructed to administer anticoagulation, and during a short delay at the prison gates, the deceased went into ventricular fibrillation (VF) arrest, from which she was successfully defibrillated. At hospital she went into VF arrest again several times, and the angiography suite team borrowed a LUCAS mechanical chest compression device from the ambulance to allow for continuous CPR whilst x-rays were being performed, as they did not have one of their own. Despite attempts at clot extraction and stent placement, she did not survive.

Inquest findings and comments

The cause of death was acute myocardial infarction; the manner of death natural causes.

The Coroner identified missed opportunities for intervention to address modifiable risk factors for cardiovascular disease whilst the deceased was in custody and noted that the prison medical centre was struggling with staff shortages and an overwhelming number of prisoners with high needs. Muster of the prison was twice the planned capacity.

The Coroner found that the treatment provided at the prison medical centre was adequate, despite the centre being previously described as 'not fit for purpose' in the 2017 Inspector of Custodial Services report. Changes made by the prison medical services were noted, and plans that the medical centre be reviewed and improved as quickly as possible was strongly encouraged.

Coroner's recommendations

No recommendations were made but the Coroner urged the relevant Health Services to consider purchasing LUCAS machines for their respective angiography services.

WA health system action

All three Health Service Providers (HSP) with angiography services have reported that their sites now have access to mechanical chest compression devices.

References

- BOLTON findings[45]

Further resources

- Office of the Inspector of Custodial Services: Inspection of Bandyup Women's Prison[46]

Discussion points

- The Coroner mentioned the use of mechanical chest compression devices in angiography suites.
- In what other areas or situations might mechanical chest compression devices be used?
- Are there any potential disadvantages or harms associated with their use?
- How is the need for new medical equipment evaluated by your Health Service?
- Custodial patients have higher levels of co-morbidities and barriers to access services.
    - How can we improve our disease prevention, management and communication systems for these patients?

[45] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_judy_sonia_bolton.aspx
[46] https://www.oics.wa.gov.au/reports/114-report-of-an-announced-inspection-of-bandyup-womens-prison/?doing_wp_cron=1595830387.2398850917816162109375

Hyperthermia

Key Message

- Heat-related illnesses are likely to be seen more commonly as the climate continues to change
- The spectrum of heat related illness ranges from mild to severe, and can progress rapidly

A 15-year-old boy died from multiple organ failure associated with hyperthermia (heat stroke) after engaging in rugby training on an extremely hot summer's evening.

The coach had decided to hold a shortened training session with more breaks than usual, after completing a heat guideline checklist and checking the conditions. Within half an hour of training drills, the boy became noticeably fatigued and was assisted to the drink station for a water break. He was unable to get up and participate in the next drill, and the coach doused him with water to cool him. Despite this, he deteriorated and became unresponsive. Ice was applied to his armpits, groin and neck, and half an hour after it was first noticed that he was unwell, an ambulance was called.

The paramedics found him to be unresponsive and in shock. His respiratory rate was very fast at 42 breaths per minute, his heart rate 180 beats per minute, and he was hypotensive and hypoxic. His temperature was over 39°C. He was transferred by ambulance to hospital, but despite air conditioning and cold intravenous (IV) fluids, his temperature rose to 41.6°C.

Active cooling continued at hospital, where he was intubated and transferred to the intensive care unit (ICU). Overnight he developed multiorgan failure and despite best efforts, succumbed three days after admission.

Inquest findings and comments

The difficulties faced by non-medical staff in differentiating between different degrees of heat-related illness was acknowledged by the Coroner, who recommended changes be made to first aid training with regard to the provision of first aid for hyperthermia. The Coroner concluded that the adults responsible for the deceased's welfare acted responsibly but due to training they had received were not equipped with the means of recognising and treating heat stroke.

Coroner's recommendations

The Coroner made one recommendation:

1. *Sports Medicine Australia, St John Ambulance and all registered training organisations who provide the nationally accredited course Provide First Aid HLTAID003 consider and, if appropriate, incorporate the principles in Professor Rogers' guide[47] into the knowledge content of the training they deliver with respect to providing first aid for hyperthermia.*

[47] Available on pp30-31 of inquest: Heat Stroke Advice for Sports Trainers and Coaches https://www.coronerscourt.wa.gov.au/_files/inquest-2019/Thomas_Torran_finding.pdf

WA health system action

Raising awareness of heat stroke and the advice highlighted in the inquest was deemed within scope as a public health issue by the Coronial Review Committee. Members agreed to disseminate the information via the public Healthy WA internet site and incorporated the principles outlined in Professor Rogers' guide about heat stroke symptoms and the first aid actions to take.

References

- THOMAS findings[48]
- Heat stroke advice on Department of Health public internet website[49]
- WA Training Accreditation Council: Special Bulletin providing Professor Rogers' guide for heat stroke to organisations delivering HLTAID0003 Provide First Aid course[50]

Discussion points

- Which groups are at higher risk of heat related illness?
- What role does Public Health have in providing guidance for sports organisations and other community groups?

[48] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_torran_jake_thomas.aspx
[49] https://healthywa.wa.gov.au/Articles/F_I/Heat-stroke
[50] https://www.tac.wa.gov.au/newsandevent/Pages/RTOs-delivering-HLTAID003-Provide-First-Aid-and-or-other-first-aid-related-units.aspx

Bariatric surgery

Key Message

- Patients' perception of risk and benefit of treatments or procedures may differ to that of clinicians.

A 44-year-old woman died from pulmonary thromboembolism as a result of an unsuspected myeloproliferative disorder following bariatric surgery.

The deceased had requested a referral for a sleeve gastrectomy after having gained weight in her 40s. Her body mass index (BMI) was 30 at the time of referral. She had made attempts to lose weight through commercial dieting programs, but had not seen a dietitian, exercise physiologist, or sought other support or treatment for weight loss.

She was reviewed by a bariatric practitioner (a general practitioner) who worked with the surgeon who performed the surgery around five weeks later. He did not exclude her from consultation with the surgeon as he regarded her as having met the criteria for weight loss surgery, which he understood to include people with a BMI > 35, or those with a BMI > 30 with comorbidities. The deceased's comorbidities were listed as sore knees, lumbar back pain and snoring, though no further investigation of these had been undertaken. The bariatric practitioner did not question her regarding her reasons for undergoing surgery, but gave her a pre-operative checklist and information about the procedure, and referred her for blood tests and to a dietitian for post-operative nutrition planning.

A few weeks later, she underwent the procedure, was given deep vein thrombosis (DVT) prophylaxis overnight and returned home the following day.

Nine days later she developed severe abdominal pain and was taken back to theatre, where instead of the anticipated gastrectomy complications, she was found to have portal vein thrombosis and splenic infarct with rupture and haemorrhage. Expert advice was sought and she was commenced on direct oral anticoagulation. Despite this, and the insertion of an inferior vena cava (IVC) filter and subsequent heparin infusion, she developed extensive thromboembolic disease and died suddenly of a massive pulmonary embolism around one week later.

Histopathology of the ruptured spleen showed extramedullary haematopoiesis without splenic enlargement and it was later determined that she had a rare acquired genetic mutation associated with myeloproliferative disorders and venous thromboembolism.

Inquest findings and comments

The Coroner was satisfied with the operative and post-operative care she had received, but also reviewed the appropriateness of the deceased having undergone bariatric surgery.

Concern was expressed by expert witnesses over the gradual lowering of BMI criteria for surgery, and the risk for self-referring patients in the lower BMI range who may be attracted to what is perceived as a cosmetic procedure without full understanding of the serious nature of the surgery and potential risks. The Coroner accepted that the surgeon was entitled to make his own opinion regarding patient suitability. It was noted that the surgeon had changed his practice around documentation, and now requires patients to write a letter explaining why they want surgery, to ensure that it is for health reasons, not cosmetic purposes.

Coroner's recommendations

The Coroner did not make any recommendations in this matter.

WA health system action

The Coronial Review Committee 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 private hospital that treated the deceased provided information on the actions that have been implemented since this case. These included:

- A Metabolic and Obesity Surgery Department Meeting being established to provide governance across all hospitals within the private group 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.
- Guidelines 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.

With regard to the broader activities in bariatric surgery across the WA health system, a commitment to address the health burden caused by being overweight or obese is ongoing. The WA Healthy Weight Action Plan 2019-2024 provides a roadmap for action over the next five years to support people who are currently overweight, or living with obesity, or are at risk of experiencing these outcomes, 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. A broad review was undertaken 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 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.

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. A pilot is planned to trial and evaluate elements of the care pathway once endorsed.

References

- DUNKEL findings[51]
- WA Healthy Weight Action Plan 2019-2024[52]
- WA Bariatric Surgery Plan[53]

Further resources

- Australian and New Zealand Metabolic and Obesity Surgery guidelines for Bariatric surgery[54]
- Bariatric-metabolic surgery: A guide for the primary care physician[55]

Discussion points

- Where do your patients obtain the information they use in decision-making? How can you ensure they receive the best unbiased advice?
- How do you navigate the variety of clinical guidelines that exist?
- How do you develop a collaborative treatment strategy with your patients when their intentions or expectations do not correspond with your advice?

[51] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_gerda_theresia_dunkel.aspx
[52] https://ww2.health.wa.gov.au/Articles/U_Z/WA-healthy-weight-action-plan
[53] http://www.health.wa.gov.au/hrit/docs/publications/WA_Health_Bariatric_Surgery_Plan%202012.pdf
[54] https://anzmoss.com.au/obesity/am-i-a-candidate/
[55] https://www.racgp.org.au/afp/2017/july/bariatric%E2%80%93metabolic-surgery-a-guide-for-the-primary-care-physician/

Colchicine overdose

Key Message

- Advice regarding treatment may vary between jurisdictions due to differing guidelines, databases, and training

An 18-year-old woman died in hospital in the Eastern States after taking a drug overdose. She had taken tablets belonging to another family member, including desvenlafaxine, verapamil, St John's Wort, and colchicine.

Within two hours of ingestion she experienced gastrointestinal symptoms and underwent initial medical assessment at an emergency department. The local Poisons Information Centre (PIC) was called but as the call came in after-hours, the call was put through to an interstate PIC where staff were on call. Decontamination by activated charcoal was considered by the treating team but was discounted after being reassured by the PIC staff that the dose was unlikely to cause severe harm as the colchicine dose ingested was estimated to be just under 0.2mg/kg, and contemporaneous guidelines suggested a dose over 0.5mg/kg would be needed to produce severe toxicity. The deceased was admitted to a medical ward for rehydration and cardiac monitoring. She deteriorated over the next day and was admitted to ICU for supportive care, later transferred to another hospital for life support, but died from multi-organ failure due to colchicine toxicity.

Inquest findings and comments

Colchicine is rapidly absorbed and there are no methods available to remove it from circulation. It prevents cell division, causing gastrointestinal distress and multi-organ failure, with death occurring within hours to days from ingestion. Early decontamination of the gastrointestinal tract is the best approach to minimising toxicity but is not without risk (aspiration pneumonitis from charcoal, best administered to an intubated sedated patient with a secure protected airway).

There are four state based and funded PICs in New South Wales, Victoria, Western Australia and Queensland. A national after-hours service (10pm – 8am) is provided by a shared roster. There is inconsistency between jurisdictions as to training of Specialists in Poisons Information (SPIs) who handle 95% of calls, and in the clinical references used. Clinical data is shared in separate databases operating on different platforms. Past attempts to construct an efficient national poisons information system have failed to progress at an intergovernmental level.

A review by several clinical toxicologists from around Australia was undertaken after this death. A new colchicine guideline was produced, recognising the potential for severe toxicity and death at lower doses than previously stated. Decontamination is now recommended for all patients. All PIC guidelines will be reviewed and updated. A pop-up box has been created to appear on PIC databases recommending all cases of intentional colchicine overdose be referred by the SPI to a clinical toxicologist

Coroner's recommendations

The Coroner made one recommendation:

1. *In the interests of public health and safety and preventing like deaths, I recommend the Australian Commission on Safety and Quality in Healthcare (ACSQHC) assist clinical experts in developing the National Poisons Information Guidelines.*

The ACSQHC reviewed the status of PICs and their efforts to form a national system and responded to the Coroner that it is a matter for the Australian Health Ministers Advisory Council (AHMAC) to advise their respective governments on how to progress. The ACSQHC also sent a letter to each State and Territory Health Department with PICs to share the coronial report.

WA health system action

In response to the ACSQHC letter, WA drafted a funding request for WA and NSW to co-lead a program of works to establish a formal National PIC Network (including the development of National Poisons Information Guidelines) and create an Australian Toxico-Surveillance Service. There was limited feedback and support for the funding request at the time and due to other priorities (the bushfire recovery and COVID-19 pandemic), it was not progressed.

In February 2020, the Toxicology and Poisons Network Australia (TAPNA) contacted the WA PIC indicating a desire to take a lead role in establishing collaborative clinical governance and standardise practices across Australasian PICs.

The WA Department of Health supports TAPNA's proposal to harmonise PICs across Australia and promote collaborative clinical governance and information sharing across the Australasian PICs, however there are some key factors that will need to be worked through e.g. governance framework, data management and privacy. Discussions with TAPNA were put on hold due to COVID-19 response priorities, but preliminary discussions will be rescheduled.

References

- GILL finding[56]

Further resources

- WA Poisons Information Centre[57]
- NSW Poisons Information Centre[58]
- Queensland Poisons Information Centre[59]
- Victorian Poisons Information Centre[60]
- Toxicology and Poisons Network Australia[61]
- Practice Standards for Australia Poisons Information Centres 2014[62]

Discussion points

- What clinical areas have been most successful in establishing national clinical guidelines? Are these applicable in all health settings?
- How can a consistent national approach to the provision of information and advice regarding poisons be developed?
- How do you access best practice advice from national or international experts?

[56] https://www.coronerscourt.vic.gov.au/sites/default/files/2019-02/ElizaGill_435916.pdf
[57] https://www.scgh.health.wa.gov.au/our-services/service-directory/poisons
[58] https://www.poisonsinfo.nsw.gov.au/
[59] https://www.childrens.health.qld.gov.au/chq/our-services/queensland-poisons-information-centre/
[60] https://www.austin.org.au/poisons
[61] http://www.tapna.org.au/
[62] https://www.austin.org.au/Assets/Files/Practice%20Standards%20for%20Australian%20Poisons%20Information%20Centres%202014[2].pdf

Supported accommodation

Key Message

- The provision of services for older aged mental health patients is challenging and requires a multidisciplinary approach.
- Despite the principles of equity in healthcare it is difficult to provide a complete range of specialist services in regional and remote areas.

A 69-year-old man died of natural causes in a mental health unit whilst an involuntary patient under the Mental Health Act.

The deceased was a celebrated playwright and musician from the Kimberley region. He had increasingly treatment-resistant bipolar affective disorder since his early adulthood after he sustained a head injury in a motor vehicle crash. He had limited insight into his illness and developed significantly disabling Parkinsonism as the result of long-term depot anti-psychotic medications. Treatment of this was limited by anti-cholinergic side-effects.

His co-morbidities included Type 2 diabetes, chronic obstructive airways disease, renal impairment and coronary artery disease. He continued to smoke heavily throughout his life.

The deceased's last admission to a mental health unit lasted for several years. He was assessed as needing high-level care for physical frailty as well as psychiatric care. A trial of respite in an aged care facility was initially successful, but attempts to care for him in the open unit was not successful as he refused medications, returned to his home in the community and relapsed despite assertive community follow-up. The deceased was transferred back to the mental health unit where he later died after an episode of breathlessness despite resuscitation efforts that were in line with formerly agreed upon goals of care.

Inquest findings and comments

The cause of death was found to be chronic obstructive pulmonary disease and coronary artery atherosclerosis.

The Coroner was satisfied that the overall level of care provided was of very good standard, but that the deceased's social and emotional well-being were not optimal due to his long-term residence in an involuntary institutional setting instead of an appropriately configured and resourced facility providing supported accommodation.

The Coroner also noted that there were barriers to the provision of allied health services to inpatients of the mental health unit that the Hospital Executive had hitherto been unaware of. The Coroner was satisfied that this issue would now be addressed by the health service.

Coroner's recommendations

The Coroner wished to add his voice to those advocating for the increased availability of mental health facilities across Western Australia and made one recommendation:

1. *That relevant government agencies consider the desirability and feasibility of establishing a facility providing long-term supported accommodation for mental health patents in the Kimberley region.*

WA health system action

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.

References

- CHI findings[63]

Discussion points

- How does the government balance equity in healthcare access with resource stewardship?
- How can we assess if our health care planning meets the needs of our community?

[63] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_james_ronald_chi.aspx