Government of **Western Australia**
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From Death We Learn 2021

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Acknowledgements

The patients and their families
Ms Ros Fogliani, State Coroner, Western Australia
Ms Sarah Linton, Deputy State Coroner, Western Australia
Mr Michael Jenkin and Mr Philip Urquhart, Coroners, Western Australia
Medical Advisors to the Office of the State Coroner, Western Australia
Dr Simon Towler, Chief Medical Officer, Department of Health, Western Australia
The Coroner's Court, Western Australia
The Office of the Chief Psychiatrist, Western Australia
The Health Service Provider Safety, Quality and Performance Units
All clinical staff involved in the reporting and review of death

The Patient Safety Surveillance Unit (PSSU) welcomes suggestions on how this publication series may be improved. Please forward your comments to PSSU@health.wa.gov.au

From Death We Learn editions can be downloaded from the following website: http://ww2.health.wa.gov.au/Reports-and-publications/From-Death-We-Learn

Contents

Background

Coroner's Court

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 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 services to improve patient safety. This information is of significant assistance to the coroner and, where properly undertaken, demonstrates the on-going commitment of 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 sixteenth annual 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 2021 calendar year as published on the Coroner's Court website as of 1 July 2022.

The cases are provided to assist in stimulating patient safety discussions across health disciplines. Organisations and individual healthcare 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, the full inquest findings can be accessed on the website of the Coroner's Court of Western Australia if readers are interested.

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.

We acknowledge 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

ALO	Aboriginal Liaison Officer/s
BHCG	Beta human chorionic gonadotropin
BiPAP	Bilevel positive airway pressure
BMI	Body mass index
CaLD	Culturally and linguistically diverse
CCTV	Closed-circuit television
CLASP	Changes in Lifestyle are Successful in Partnership
CLU	Coronial Liaison Unit
CPAP	Continuous positive airway pressure
CRC	Coronial Review Committee
CRP	C-reactive protein
CT	Computed tomography
CTG	Cardiocotography
CTO	Community Treatment Order
DCPFS	Department of Child Protection and Family Support (now Department of Communities)
DIBP	Department of Immigration and Border Protection
ECG	Electrocardiogram
ED	Emergency department
EMR	Electronic medical record
FAST	Focussed assessment with sonography for trauma
GP	General Practitioner
GPO	General Practitioner Obstetrician
HDU	High dependency unit
HWS	Healthy Weight Service
ICU	Intensive care unit
IFS	Intrapartum fetal surveillance
LFTs	Liver function tests
MET	Medical emergency team
MDT	Multidisciplinary team
MGP	Midwifery Group Practice
MHC	Mental Health Commission
MLA	Member of the Legislative Assembly
MP	Mandatory policy
MRI	Magnetic resonance imaging
NIV	Non-invasive ventilation
NELUSCS	Non-elective caesarean section
OIS	Oncology information system
OMS	Oncology management system
PoCUS	Point-of-care ultrasound
PORT	Post-operative radiotherapy

PPE	Personal protective equipment
PSSU	Patient Safety Surveillance Unit
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
SPOCC	Statewide Protection of Children Coordination Unit
TCMHS	Transcultural Mental Health Service
TGA	Therapeutic Goods Administration
VBAC	Vaginal birth after caesarean
WCC	White cell count
WEAT	WA Emergency Access Target

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 Coroner's Court. Its main function is to facilitate quality improvement activity throughout the WA health system through the dissemination of health-related coronial inquest findings and recommendations to appropriate stakeholders for implementation.

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 findings and 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 inquest findings and recommendations. Coronial inquest findings and recommendations are evaluated by members and decisions are made about the level of response required. Members may 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 inquest findings, recommendations and actions taken to improve patient safety are communicated to the State Coroner in a biannual progress report.

The CLU continues to work with the Coroner's Court to share lessons learned from mortality review to improve future patient care.

Introduction to inquested cases

Under the Coroners Act every regional magistrate is contemporaneously a coroner. However, in practice the majority of Western Australian inquests in 2021 were conducted by the State Coroner Ms Rosalinda Fogliani; Deputy State Coroner Ms Sarah Linton; and Coroners Mr Michael Jenkin and Mr Philip Urquhart.

There were 2,942 deaths reported to the Coroner's Court for full investigation in the 2020-21 financial year, an increase from 2019-20 (n=2,573)[1]. A further 1,425 cases were finalised with death certificates. Of the 1,994 cases completed during 2020-21, 1,937 deaths were finalised by inquiry (704 were backlog cases exceeding 12 months), and 57 investigations were finalised by public inquest (55 were backlog cases). Ten of the cases that proceeded to public inquest were discretionary (not mandated under the Coroners Act).

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*.

A 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, children subject of a protection order under the *Children and Community Services Act 2004* 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 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; from August 2019, the executive summary of the biannual 'Progress Report for Health-Related Coronial Recommendations' has been made available publicly online via the Coronial Liaison Unit website.

[1] Office of the State Coroner. Annual Report: 2020-2021 [internet]. 2021. Government of Western Australia. Accessible at https://www.coronerscourt.wa.gov.au/P/publications.aspx

Delayed diagnosis

Key Messages

- Focussed physical examination is an important part of patient care.
- Prisoners have limited agency for managing their own health care.

A 63-year-old man died from metastatic rectal carcinoma whilst a sentenced prisoner.

Imprisoned for two decades, his healthcare for the last third of his life had been provided through the prison system. In addition to hypertension, osteoarthritis, migraines and prostatic hypertrophy, the deceased had a history of anal and rectal problems for the last ten years of his life with complaints of rectal bleeding, anal itch and haemorrhoids. He was usually reluctant to have physical examination, especially per rectal examination, and did not like being taken to the hospital as he found the prison van claustrophobic.

In the last few years of his life the deceased also reported altered bowel habit and pain on defecation and informed the prison medical officers on several occasions that he could feel a mass inside his rectum. This was never checked by per rectal examination by prison staff, agreeing with the deceased's assumption that it was a haemorrhoid.

He was eventually referred for surgical review. The referral did not contain any mention of the mass, and whilst the urgency of referral indicated he should be seen within 30 days, he was seen by a surgeon 100 days later when the surgeon conducted a clinic at the prison. At that review, a chronic anal fissure was diagnosed based on external examination only, and sphincterotomy booked for two months later. This was subsequently rescheduled due to hospital capacity issues.

During the next few months his symptoms worsened, and he reported tenesmus in addition to worsening pain, alternating constipation and diarrhoea. When he developed difficulty passing urine, he was taken to the emergency department. The medical notes describe a history of anal pain and constipation. Examination recorded as tenderness in the anal canal at five o'clock, no fissure or palpable mass. The case was discussed with the surgical registrar over the phone, who recommended sending a letter to the surgeon's rooms regarding expediting follow-up and the deceased was discharged back to prison.

His pain worsened, and he started to lose weight. A month later blood tests revealed abnormal liver function and 'a likely acute infective or malignant process'. He was transferred to hospital for urgent imaging and investigation. Examination under anaesthesia revealed a large rectal mass about 1cm inside the rectum. Histopathology confirmed this to be poorly differentiated adenosquamous carcinoma, and imaging revealed widespread metastases. He rapidly developed liver failure, was deemed too unwell for chemotherapy, and was palliated.

Inquest findings and comments

The cause of death was metastatic rectal carcinoma; the manner of death natural causes. Earlier diagnosis, whilst not being guaranteed to have changed the ultimate outcome, may have improved his quality of life if not length of life.

Quality of supervision, treatment and care

The deceased's risk factors for colorectal and anal cancer were discussed by the coroner, including age, weight, sedentary lifestyle, low-fibre diet, and being found after his death to have human papillomavirus (HPV) subtypes 16 and 18 as a result of sexual activity.

The coroner found that the medical care in prison was commensurate with community standards until the last few years of the deceased's life, from which point onwards there were several missed opportunities to diagnose the cancer. These multiple missed opportunities for earlier identification of the cancer were discussed, including relying on the patient's self-diagnosis, not conducting per rectal examination or documenting discussion of risks involved in omitting such an examination, the absence of annual health reviews or faecal occult blood tests, monitoring of weight, or blood tests.

Improvements made subsequently by the Department of Justice, Health Services were noted, and the coroner made two recommendations for the Department of Justice regarding Prison Health Services.

Coroner's recommendations

The coroner made two recommendations:

1. To ensure that when prisoners are referred to external agencies those referrals are managed in a timely and appropriate manner, the Department of Justice should consider establishing a system that alerts the Prison Health Service when such referrals are overdue. The Department of Justice should also consider allocating sufficient resources to enable a project team to be established to finalise the work currently being undertaken by Dr Joy Rowland in establishing a system to monitor and track these referrals.
2. The Department of Justice should consider amending the Health Services Policy relating to annual health reviews so that priority is given to reviewing vulnerable and older prisoners. Further, Department of Justice should allocate appropriate resources to enable these annual reviews to be conducted in a timely manner.

WA health system action

Coronial Review Committee members noted that there is currently no relationship to WA Health in terms of Justice Health clinical governance or patient safety systems. The CLU extended an invitation to the Department of Justice to discuss the case with a view to sharing resources about clinical governance.

References

- Scott inquest findings

Further reading and resources

- WA Department of Health Clinical Governance Framework
- Australian Commission on Safety and Quality in Health Care: National Model Clinical Governance Framework
- Australian Commission on Safety and Quality in Health Care: Clinical Governance Standard

Discussion points

- How can diagnostic accuracy be improved?
- Could improved health literacy have improved the outcome in this case?
- How can people in custody be given more control over their health outcomes?
- How mature is clinical governance in your health service?

Unpredictable behaviour

Key Message

- WA Police Force and WA Health may have different approaches to managing people with behavioural alteration, yet they share a similar duty of care to the public and individuals.

A 40-year-old man died from penetrating wounds to the chest sustained as a result of unlawful homicide.

The offender was a 38-year-old man with a background of criminal convictions, and heavy alcohol, cannabis and methamphetamine use. He had been released from a police station shortly before breaking into the deceased's apartment and attacking him. The coroner held an inquest to review the circumstances of the death and the interactions between the police officers and the offender, noting that it is not the role of the coroner to assess the evidence for civil or criminal liability.

The offender had been behaving aggressively towards an old friend and her daughter at the friend's house around midnight. The woman called '000' twice, expressing concern for his mental health and stating that he had taken drugs. Several neighbours also placed calls to '000' regarding "a huge domestic" with screaming and smashing noises.

The offender left the house ten minutes after the first call had been placed. Police officers had been dispatched, and they intercepted him nearby. He became aggressive during the encounter and was arrested for behaving in a disorderly manner following an altercation with the police officers.

The offender was held at the police station for around 20 minutes. He was assessed by the police as being drug-affected rather than mentally unwell, and not fit for interview. It was decided that he would be released and later charged by summons with respect to the altercation with police officers. Police officers chose to drive him to the apartment complex he had given as his home address, not knowing he had not lived there for many months.

The offender broke into the deceased's apartment and stabbed him with two knives. He then entered another unit via the balcony and went to take a shower. The occupant called the police who attended and apprehended the offender.

The deceased was taken to hospital where he died after emergency surgery was performed to remove the knives.

Inquest findings and comments

The offender was sentenced to life imprisonment for murder prior to the inquest. On the basis of reports from two psychiatrists, the sentencing judge was satisfied that the offender was undergoing a psychotic episode at the time of the murder.

The decision to release the offender rather than detain him under the *Criminal Investigation Act 2000* or the *Protective Custody Act 2000*, or to transport him to hospital for medical assessment under the *Mental Health Act 2014*, was explored by the coroner. In addition to police communication and subsequent improvements in those processes the coroner found that the police officers did not have proper regard as to the provision in the Mental Health Act that states that serious or permanent effects of drug usage do not exclude mental illness, but acknowledged the impact of their prior experiences of drug-affected people being released from hospital without full assessment back into the care of police.

The coroner noted the Mental Health Co-Response model, which was being trialled in metropolitan Perth, but not available in this city at the time of the murder. The coroner supported the recommendations regarding the expansion of the model made by the State Coroner in 2020 following the Key inquest and incorporated them into this finding.

Coroner's recommendations

The coroner made three recommendations:

1. That the Mental Health Co-Response continue to be funded, and that consideration be given to providing the Western Australia Police Force and the Western Australia Mental Health Commission with additional, external funding in order to support expansion of the programme in a way that meets demand.
2. That consideration be given to providing the Western Australia Police Force and the Western Australia Mental Health Commission with additional, external funding in order to support the expansion of the Mental Health Co-Response in metropolitan areas of Perth.
3. That work continue on the planning of the Mental Health Co-Response in regional areas of the State, and consideration be given to providing the Western Australia Police Force and the Western Australia Mental Health Commission with additional, external funding in order to support the expansion of the Mental Health Co-Response into regional areas.

WA health system action

The Coronial Review Committee members noted the continuation of the Mental Health Co-response in Rockingham, Peel and Cockburn areas, with funding to expand the service to operate from the Mandurah Police Station.

Funding has been made available to extend the service to seven days per week in eight metropolitan locations and the addition of two regional mobile teams in Bunbury and Geraldton. Further to this this, Aboriginal mental health workers are available to the regional teams, providing informed support from a local knowledge and cultural perspective.

The service expansion is to include the provision of additional mental health and alcohol and other drug support at the Perth Watch House (inclusive of an Aboriginal Mental Health worker), an increase in mental health practitioners at the Perth Operations Centre, and additional training for police officers and Mental Health Practitioners, particularly around trauma informed care.

The WA Police Force, Health Service Providers and MHC are working together on the expansion in the metropolitan area, and how this may be improved and enhanced to ensure the best possible outcomes for all.

References

- Martin inquest findings

Further reading and resources

- WA Methamphetamine Action Plan

Discussion points

- Assessment and containment of people who may be drug-affected or have behavioural alteration continues to present challenges for the WA Police Force and Health, with gaps in care present at times. How can this be improved?

Complex cancer care

Key Messages

- Miscommunication is often cited as the most common contributory factor in adverse events in all industries, not just in healthcare.
- Electronic medical systems have many benefits but require careful implementation and ongoing review to ensure they are the best fit for all aspects of health care.

A 73-year-old man died from disseminated malignancy (advanced lung carcinoma and tongue carcinoma) having not received optimal care as planned.

One year earlier the deceased had been referred to a tertiary hospital Head and Neck multidisciplinary team (MDT) for treatment of an oral cancer. When lung cancer was discovered during work-up, the Head and Neck MDT referred him to the Thoracic MDT who conducted further investigations to clarify the type and staging of the lung cancer.

The Thoracic MDT decided that initial radiotherapy of the lung cancer could be postponed in order for the Head and Neck MDT to surgically excise the oral cancer. The chance of a cure for the oral cancer was greater than for the lung cancer.

The treatment plan originally developed was:

1. Excision of oral cancer
2. Radiotherapy with radiosensitising chemotherapy (carboplatin and etoposide) for the lung cancer
3. Post-operative radiotherapy (PORT) +/- radiosensitising chemotherapy (cetuximab) for the oral cancer (ideally within three months of surgery).

The surgical excision occurred as planned, but due to a number of factors the deceased was subsequently given the wrong chemotherapy during radiotherapy for the lung cancer and was not referred for PORT for the oral cancer.

When the errors in treatment were realised, the optimal window for PORT for the oral cancer had lapsed. Monitoring of the lung cancer showed that it had metastasised to his liver. The treatment plan was changed to palliation.

Inquest findings and comments

The coroner found that the manner of death was natural causes and the cause of death was disseminated malignancy (advanced lung carcinoma and mouth carcinoma) in a man with co-morbidities including chronic obstructive pulmonary disease.

Coroner's comments on the care provided

Multiple potential contributory factors were explored during the inquest.

1. Quality of communication following MDT meetings

   MDT meetings were usually held weekly. Ideally discussions and recommendations would be carefully documented, and copies provided to MDT attendees, the patient, the GP, and filed in the patient notes. MDT notes were stored in the electronic medical record (EMR) in a folder labelled 'Discharge Summaries' so may not have been easy to find. Commonly the tasks of taking and distributing notes, and making referrals, would fall to the most junior medical officer on the team.

2. Communication of treatment plan

    - The electronic referrals from the Thoracic MDT to both the radiation oncology and medical oncology teams mentioned both cancers, the plan for surgical excision of the oral cancer, and referral to the other oncology team, but did not specify that this was a request for treatment for the lung cancer.
    - Radiotherapy is booked first, and chemotherapy scheduled accordingly to optimise treatment. The radiation oncology team scheduled treatment for the lung cancer to commence after discharge from hospital following oral surgery and communicated the dates for treatment to medical oncology, not specifying which cancer was being targeted.
    - The medical oncology team assumed the referral for sensitising chemotherapy and the radiotherapy dates booked were for PORT for the oral cancer as had been discussed at the Head and Neck MDT meeting, not noticing that the referral was from the Thoracic MDT. Staff involved suggested a 'reason for referral' box should be added to the template in the electronic referral system.
    - The clinic letter from medical oncology to radiation oncology detailing the plans for chemotherapy was not received until 61 days after the clinic appointment was held, just days before the six weeks of radiotherapy treatment was due to finish. Had it been received earlier, the error in choice of chemotherapy would have been noted prior to starting radiotherapy. It was suggested that extra physicians would help manage the workload, enabling clinicians to attend to administrative tasks in a more timely manner, but funding constraints prevented this.
    - No referrals for PORT or follow-up with the Head and Neck MDT after discharge were made. Potential causes for this were not fully explored at inquest. The existence of booked dates for radiotherapy may have been assumed by the Head and Neck MDT to have been for PORT rather than for the lung cancer.

3. Coordination of care for patients requiring complex treatment

    Multiple teams were involved in the delivery of care for the deceased and the two cancers – Thoracic MDT, Head and Neck MDT, medical oncology and radiation oncology. There was very limited access at the health service to Complex Cancer Care Coordinators, and none were involved in coordinating the deceased's care. The coroner urged the health service to support the employment of additional Care Coordinators, noting the introduction of Care Coordinators to the Head and Neck cancer team and the Lung cancer team since the death.

4. Medical records and integration of digital workflows

    Whilst the medical and radiation oncology services are co-located at the health service Cancer Centre, radiation oncology is provided by a private company and medical oncology is provided by hospital staff. The private radiation oncology service has its own computer system which is not compatible with or linked to the hospital's EMR. Integration of information between the two is by way of uploading scanned documents. The private radiation oncology staff had access to the hospital's EMR; but hospital staff did not have access to the radiation oncology information system.

The coroner urged the health service to urgently liaise with the WA Department of Health with a view to prioritising the implementation of a state-wide oncology information system (OIS), versions of which are used in all other mainland states.

Coroner's recommendations

The coroner made two recommendations:

1. To ensure the accuracy of notes and treatment plans recorded following multidisciplinary team meetings (MDT) held at the hospital, MDT notes should be taken by a suitably experienced clinician or health practitioner. Where this is not possible, MDT notes should be checked by a suitably experienced clinician prior to being circulated.
2. To ensure that referrals are triaged appropriately and in a timely manner, the e-Referral system used at the hospital should be modified to include a text box requiring the referring clinician to state the reason for the referral and, in general terms, the nature of the treatment or service being requested.

WA health system action

The health service has established best practice terms of reference for multidisciplinary teams. These teams are being supported by technology solutions to ensure this work will streamline processes including automating data linkage to pre-populate data where possible, establishing formal minimum agenda items and inbuilt approval and communications automation.
Further, the e-Referral system now includes a mandatory text box requiring the referring clinician to state the reason for the referral and nature of the referral. Modifications have been made to the e-referral system for oncology to include mandatory fields including specifying the cancer involved, and whether the patient has been referred to radiation oncology. In addition, there is a field to indicate whether the patient has been discussed at an MDT meeting.

The service is also now supported by cancer coordinators. An additional role to support navigation of complex care.

There is a plan to implement the CHARM® Oncology Management System (OMS). The OMS will replace the existing paper toolset with a fully digitised system capable of managing the prescription, validation, ordering, dispensing and administration of chemotherapy.

References

- Craig inquest findings

Further reading and resources

- WA Cancer Plan 2020-2025
- Australian Cancer Plan

Discussion points

- How can the navigation of complex models of care be made simpler? How can patients best be supported when trying to coordinate their own care?
- Surgical Safety Checklist and Team Time Out have been introduced into operating theatres to reduce serious adverse incidents such as wrong site/wrong side surgery. Is there a role for similar processes elsewhere in healthcare? How could these be developed and implemented?

Surgical complication

Key Messages

- Responding to clinical deterioration requires a timely and collaborative response.
- Medical notes have medico-legal significance as well as being essential for coordination of good clinical care.

A 68-year-old man died from surgical complications following delays in post-operative management after the removal of his inflamed gallbladder.

The deceased was admitted to a regional hospital after three days of abdominal pain. He was afebrile with raised inflammatory blood markers and an ultrasound confirmed the presence of gallstones. The locum surgeon present was concerned that his comorbidities of high blood pressure, poorly controlled type 2 diabetes, chronic kidney disease and heart failure might contribute to a risk of sepsis and so performed a laparoscopic cholecystectomy.

The deceased became haemodynamically unstable within 15 minutes of the end of the procedure. There was transient improvement with boluses of fluid, inotropes and vasopressors, and the anaesthetist was concerned there was intra-abdominal bleeding. The surgeon disagreed as the deceased's abdomen was soft and not distended, and there was not excessive fluid seen in the surgical drain. He believed that a septic shower was causing the low blood pressure and asked for more antibiotics and "a scan", meaning a CT scan. The anaesthetist believed that the patient needed to be returned to theatre urgently to control suspected bleeding but could not persuade the surgeon. Senior nurses and two other anaesthetists who attended later also believed bleeding to be the cause of the patient's condition but either did not speak up to the surgeon or were not heard.

A medical emergency call was put out due to ongoing low blood pressure despite treatment. As other staff arrived, there was a lack of clarity as to who was acting as team leader, and concerns over the risk of another general anaesthetic given the man's low blood pressure. Blood tests showed acidosis and a reduction in haemoglobin, though it is not clear if the clinicians were aware of the results. Units of blood were transfused. Bedside ultrasound was conducted several times, and it was regarded as negative as no significant free fluid was seen.

The team were concerned about the risk of transferring the deceased to the radiology department for a CT scan due to his condition. A formal ultrasound was performed two hours after the operation at the suggestion of the radiologist which confirmed the presence of intra-abdominal fluid, and the patient was operated on again an hour later. Three litres of blood were drained, and a damaged aberrant branch of the cystic artery was repaired.

He was transferred to a tertiary hospital the next day with multiorgan failure as the result of prolonged hypotension. Despite treatment in the Intensive Care Unit, he did not recover and was palliated with his family present.

Inquest findings and comments

The coroner found that death occurred by misadventure with the inadvertent cutting of an aberrant branch of the cystic artery leading to massive blood loss and subsequent multiorgan failure. It was noted that this is a recognised complication of cholecystectomy, with 20% of the population having aberrant cystic arteries.

Comments on quality of supervision, treatment and care

Multiple reports and reviews were considered by the coroner.

Expert surgical opinion was sought by the coroner regarding the case and the surgical approach used by the surgeon. The patient's cystic duct was identified and clipped before the cystic artery, as described in standard surgical texts and as per the surgeon's training. The independent expert witness asserted that it was less risky to identify and clip the artery first, as it can be harder to find after the duct has been transected, is at risk of damage and the risk of immediate or delayed bleeding harder to control or recognise than bile leakage from a damaged cystic duct.

The anaesthetist had expressed concern over the 'ooziness' of the gallbladder bed and the look of the fluid during the wash-out, however the surgeon maintained the surgical field was consistent with an inflamed gallbladder.

A drain had been inserted in anticipation of a small amount of post-operative bleeding, due to the state of the operative field and the technical challenge it presented. The operation report instructions were that it was to be kept on gravity rather than low-suction setting, thus reducing its efficacy and hence leading the team to underestimate the volume of blood loss.

The use of point of care ultrasound was discussed, including its utility in non-trauma situations. The ongoing absence of a policy relating to competency standards and clinical indications was noted.

The coroner discussed the communication breakdown between team members and the lack of clarity as to who the medical emergency team leader was. The recommendations from the Significant Event Review conducted previously were highlighted, including providing training programs in graded assertiveness and escalating serious adverse events to the Senior Medical Officer or Regional Medical Director as soon as possible.

The use of locum staff was reviewed, with the coroner noting that it had an impact on the ability to build a culture of trust and respect at the hospital. The coroner was of the view that it would be preferable for the use of locum staff at the hospital to be kept to a minimum and for current staffing levels to be reviewed.

The anaesthetist had written notes about the case using an electronic records system shared across other hospitals in the area. This was no longer supported at the regional level, although it was still widely available and used as it could provide printouts to place in the hospital notes that were a legible alternative to handwritten notes. These notes were printed out, but were ultimately ordered to be removed from the patient medical record by another clinician, who deemed them to be a medico-legal report. No effort was made to capture the content of the removed notes in the medical record. The clinician involved subsequently faced disciplinary proceedings.

Coroner's recommendations

The coroner made five recommendations:

1. For the guidance of clinicians, the Health Service should, as a matter of priority, develop a policy for the use of point-of-care ultrasound (PoCUS). The policy should set out minimum education, training and credentialing requirements for practitioners using PoCUS as well as guidance as to the appropriate clinical circumstances in which PoCUS should be used.
2. The Health Service should amend its Health Records Management Policy to provide guidance to staff as to exactly what constitutes a medico-legal report and why such documents may not appear on a patient's health record.
3. The Health Service should amend its Health Records Management Policy to provide that, as a general rule, entries made by clinicians in or for a patient's health record are not to be removed, left unfiled or deleted. Where the person in charge of a health service determines

that a clinician's entry is to be removed from, or not placed in a patient's health record, that person should clearly document (in the relevant health record), exactly what has been removed or not placed on the patient's medical record and the reasons for that decision, having regard to any issues of legal professional privilege that may attach to the document. Further, any document containing a clinician's entry that has been removed or not placed on a patient's health record should be retained by the relevant health service.

4. The Health Service should take steps, including the provision of training, aimed at improving communications between clinicians involved in patient care. In particular, to ensure that in a situation where clinicians disagree as to the management of a patient, there is a process in place to resolve that disagreement in a timely and efficient manner.
5. The Health Service should amend its Clinical Escalation Including Code Blue – Medical Emergency Response Policy to provide that the role of Medical Emergency Response Team Leader is clearly identified at the start of the Medical Emergency Response call and thereafter when that leadership role changes.

WA health system action

In response to recommendation 1, the Health Service has developed the *Use of Focused Ultrasound for Diagnostic Purposes in Emergency Departments Guideline.* The guideline includes minimum education, training and credentialing requirements for practitioners using ultrasound at the point-of-care as well as guidance as to the appropriate clinical circumstances in which it should be used.

In consideration of recommendation 2 and 3, the Health Service Health Records Management Policy and Documentation Clinical Practice Standard have been reviewed. The review found that the documents provide adequate guidance on what constitutes a medico-legal report and why such documents may not appear on a patient's health record. In response to recommendation 3, the Standard was amended and now includes the following requirement "entries made by clinicians in or for a patient's health record are not to be removed, left unfiled or deleted unless an appropriately authorised person determines it is to be removed in compliance with the requirements of relevant legislation".

Each WA Health Service Provider considered recommendation four. All Health Service Providers offer training to staff, and some Health Service Providers and individual hospitals have specific programs in place to support staff to speak up when clinicians disagree on the management of a patient. It was noted that whilst these programs have worked successfully in some Health Service Providers, others have found them to be less effective and that good cultural engagement can impact upon successful implementation.

In response to recommendation 5 the Health Service *Recognising and Responding to Acute Deterioration (RRAD) Policy* was reviewed and republished in November 2021 to include a clear statement that the role of Medical Emergency Response Team Leader is to be clearly identified at the start of the Medical Emergency Response call and thereafter when that leadership role changes.

References

- Churchill inquest findings

Further reading and resources

- Australian Commission on Safety and Quality in Health Care: Communicating for Safety Standard
- WA Recognising and Responding to Acute Deterioration Policy
- PoCUS - Where do I begin? NSW Emergency Care Institute

Discussion points

- What barriers commonly hamper good conflict resolution? How is this managed in your workplace?
- Point-of-care ultrasound is increasingly being used in healthcare. What benefits and risks does this pose in quality patient care? How does your organisation manage PoCUS training, credentialing, use, and results interpretation?

Severe childhood obesity

Key Message

- Obesity is a complex multifactorial condition to which social and environmental factors may contribute.

The deceased was almost four years old and weighed 36kg when she died unexpectedly at her foster carers' home.

She was 2.8kg in weight when she was born in a remote community. Her community held a traditional ceremony to help her gain weight, and she subsequently developed hyperphagia and severe obesity. Staff at the children's hospital could find no underlying diagnosis despite extensive investigation. Her BMI was probably in the low 30s at one stage, with a peak weight of 41kg.

She was evacuated from her community multiple times in the first two years of life for health issues. When she was 21 months old staff at the local community health clinic made a referral to the Department of Child Protection and Family Support (DCPFS) raising concerns over obesity and developmental delay. On assessment, no evidence of harm or neglect was found, and community support and monitoring were initiated.

She was subsequently admitted to hospital in the nearby regional town with asthma. She had gained weight and couldn't stand or walk despite being two years old. DCPFS support to the family was increased and she was referred to the respiratory outreach team, who arranged for her admission to the specialist children's hospital for full assessment of her breathing problems. She weighed 27.9kg on admission. Her family were seen feeding her calorie rich food when visiting. Extensive review and investigations were carried out during a 19-day admission. On return to the region, she spent most of the next 5 months in hospital, with several failed attempts to discharge her back to her family.

DCPFS investigated allegations of neglect at this point, deeming that a return to the remote community would pose a major threat to her life, and so she was taken into the care of the Chief Executive Officer of DCPFS and entered foster care in Perth on discharge from the regional hospital.

She was also referred to the Changes in Lifestyle are Successful in Partnership (CLASP) – an outpatient, family-based, lifestyle and educational weight management program that ran in the metropolitan area, but assessment was postponed initially in the hope that a change of environment would lead to sustainable weight loss.

A sleep study confirmed severe sleep apnoea, and she was started on CPAP at night, with good effect when it was used.

Her grandparents won an interim court order to take over her care from DCPFS, and she returned to the regional town with ongoing community support. She gained 8kg in the next four months and eventually became critically ill, necessitating admission to ICU. At discharge, she was taken into the care of the Chief Executive Officer of DCPFS again but remained living with her grandparents until a planned admission in the specialist children's hospital for review of medical complications from obesity including severe pulmonary hypertension. During this admission she experienced several unexplained episodes of loss of consciousness which reduced in frequency during the admission. BiPAP was trialled as she wasn't tolerating CPAP well, and she was discharged to new foster carers.

She was seen at CLASP and they advised a return to CPAP due to suboptimal BiPAP use, but after another sleep study she resumed BiPAP. She was reviewed at the respiratory outpatient

clinic a month later, and other than taking antibiotics for a mild chest infection, was thought to be doing well.

Two days later she died unexpectedly at home. She had fallen asleep on the floor in front of the television as was common for her, and when her foster carers tried to move her, they found that she was unresponsive. Resuscitation efforts were unsuccessful.

Inquest findings and comments

At post-mortem, the child was 36kg in weight and 1.13m in height, with a BMI of 28. There was no evidence of injury, alcohol or common drugs. She had pneumonia, *Staphylococcus aureus*, *Haemophilus influenza*, enterovirus and rhinovirus were present. The cause of death was declared to be bronchopneumonia in an infant with obstructive sleep apnoea, and the manner of death natural causes.

The coroner was satisfied with the supervision, treatment and care provided by hospitals and healthcare providers, and was satisfied with the adequacy of supervision, treatment and care provided by DCPFS, noting improvements the Department have subsequently brought in. The coroner also noted:

- Non-Invasive Ventilation (NIV) machines that support remote monitoring have been introduced. The older machines are now for use by stable patients who are not new to NIV
- A Positive Pressure Initiation Clinic has been introduced to support patients and carers in learning to use NIV at home
- There is increased support for carers of patients with complex needs including the Connect Care programme.

The coroner commended the Child and Adolescent Health Service for the introduction of these improvements.

A 2015 review of the CLASP program highlighted the need to adapt the program to be more culturally appropriate for Aboriginal families, and a new model was piloted until funding ceased in early 2017.

The coroner noted that the CLASP program has been superseded by the Healthy Weight Service (HWS), located at the Endocrinology Department at the children's hospital. The service is a multi-disciplinary tertiary obesity clinic aimed at lifestyle change and management of obesity-related comorbidities for children aged 16 years and under. It consists of specialised clinicians which include paediatricians, nurses, dieticians, social workers, physiotherapists and psychologists, which has demonstrated success in reducing the weight and health risk in participants.

The HWS is Perth-based outpatient only service with no outreach capacity. Staff in rural and remote areas are engaged to manage children with obesity who cannot attend HWS. Ad hoc phone support is provided, but at the time of inquest there was no staff up-skilling program from the children's hospital for rural/remote staff to manage paediatric obesity. Telehealth is being trialled, but the coroner acknowledged its limitations in direct physical assessment. As at June 2019, there is no directly funded Aboriginal staff input into the HWS.

Recommendations were made by a paediatrician involved with HWS and the coroner strongly urged that they be considered, namely:

- an outreach service for paediatric respiratory that provides support and ensures compliance with NIV machines
- training to rural child health nurses, families and foster carers for NIV machines.

Coroner's recommendations

The coroner made two recommendations:

1. In order to address childhood obesity in remote and regional areas, I recommend the Western Australian government considers introducing an outreach service for the Healthy Weight Service Clinic at Perth Children's Hospital.
2. In order for the program offered by the Healthy Weight Service Clinic to be culturally appropriate for Aboriginal families, I recommend that the Western Australian government considers introducing, on a permanent basis, the pilot program offered by the Healthy Weight Service Clinic (sic) from mid-2015 to early-2017.

WA health system action

Discussions are ongoing to seek the most effective model of care in this complex area. Clinical service planning continues to consider secondary, tertiary and quaternary paediatric services and provide recommendations to inform whole of health system planning to meet the demand for paediatric health needs.

References

- Child AM inquest findings

Further reading and resources

- Fair Foundations: The VicHealth Framework for health equity
- Public Health Association of Australia: Health Equity Policy
- National Health and Medical Research Council Guidelines for Guidelines: Equity
- Australian Institute of Health and Welfare Health Inequalities in Australia: morbidly, health behaviours, risk factors and health service use
- Australian Government Department of Health and Aged Care National Action Plan for the Health of Children and Young People: 2020-2030
- Australian Government Department of Health and Aged Care National Obesity Strategy 2022-2032

Discussion points

- What are social determinants of health inequities? How can equity in health be promoted?
- Over 50% of Australian adults are overweight or obese; and rates are increasing in children and adolescents. Discuss evidence-based actions and strategies.

Unexpected death in a mental health unit

Key Message

- Environmental design and staffing levels should allow for patients requiring high dependency unit level care to be provided with more support and closer observation than those requiring general ward level care, regardless of diagnosis.

A 38-year-old man died unexpectedly from a cardiac arrhythmia whilst an involuntary patient in a mental health unit.

The deceased had a long history of a treatment-resistant psychotic disorder, variably diagnosed as schizophrenia and schizoaffective disorder. This was complicated by poor adherence to prescribed medication, and by illicit drug use. He was well supported by his parents and the local Mental Health and Drug Service. He received regular depot antipsychotic medication, and oral medications were dispensed to him at home by his mother. Clozapine was not considered to be a viable treatment option as this would require regular blood tests, which he routinely refused. He was known to become aggressive when his mental health deteriorated, requiring admission to hospital where he would usually settle quickly with oral medication.

The man was at high risk of cardiovascular and metabolic disease, but repeatedly refused comprehensive examination or investigation of his physical condition. He was obese, weighing 160kg at the time of his death. Metformin had been commenced for borderline raised blood sugar levels. His blood oxygen levels were noted to be in the high 80s or low 90s on many occasions in the year before he died, with normal chest x-ray, clear chest on examination, and unremarkable ECGs. It was not clear if his low oxygen levels were due to chronic obstructive pulmonary disease or to obesity hypoventilation as he never underwent lung function tests.

During an episode of deterioration of his mental illness, he was admitted to the High Dependency Unit (HDU) as an involuntary patient. His temperature, heart rate, respiratory rate and blood pressure on arrival were unremarkable. His oxygen saturation was 92%. He was too agitated to allow further physical examination, ECG or blood tests to be performed on his first day in the unit. The treating team were mindful of risks of sedation given his physique and suspected but unconfirmed medical conditions. A need for repeated measurement of vital signs was balanced with concern for the potential of escalating agitation.

Patients admitted to the HDU were to have 15 minutely visual observations, usually recorded as respiratory rate on an observation chart covering a 24-hour period from midnight to midnight. The HDU consisted of two bedrooms, a small shared lounge area and a small contained courtyard. Entry to the unit is through an ‘airlock’ consisting of two sets of doors. Nursing staff were not to enter the unit alone for safety reasons. Staffing levels and the need to attend to patients in the main mental health unit meant that the visual observations were often undertaken through a window from outside the HDU, requiring a torch at night.

Overnight the deceased was seen to be up and about at 11pm and 2am. Nursing staff believed him to be sleeping until around 8:15am, shortly after which they entered the HDU to wake him for the day. He was cold and lifeless. A MET call was put out, resuscitation attempts commenced but were unsuccessful. Challenges included accessing the MET call button, which was located outside of the HDU, the difficulty the attending staff had in finding where the emergency was occurring, and in accessing the head of the bed which was fixed in place. The GP anaesthetist attending concluded that given the coldness of the body and presence of early rigor mortis that the deceased had probably died a few hours earlier than nursing visual observations would suggest.

Inquest findings and comments

The cause of death was found to be consistent with acute cardiac arrhythmia in a man with focal coronary atherosclerosis and morbid obesity. The history of chronic schizoaffective disorder was considered a significant contributing factor, given it is associated with an increased risk of sudden cardiac death. The manner of death was found to be natural causes, and the coroner agreed with the GP that the death was likely to have occurred before the last set of visual observations taken at 8:15am.

Comments on the quality of supervision, treatment and care

Expert opinion of his care was sought and was that the community management and long-term care provided in this very difficult case was exemplary, but despite this he had a very poor prognosis.

The coroner was unable to establish a clear picture of what had happened during the night shift as the HDU observation chart from the day of the death had gone missing, and the nurse who had looked after the deceased overnight had died prior to the inquest, having not been interviewed by police. The coroner found that it was likely that visual observations had been taken through a door overnight rather than in person due to staffing levels and safety concerns.

The coroner commented on the potential missed opportunities to record additional physical observations but acknowledged it may not have altered the outcome of sudden cardiac death.

The coroner noted that the health service conducted a clinical incident investigation following the death and implemented several recommendations.

- A new MET call button was installed much closer to the HDU. Mental health unit nursing staff undertook basic life support training. MET response simulation training and drills occur in different parts of the hospital, and standardisation and regular stocking of MET trolleys, including ensuring the availability of PPE.
- There has been an increase in staffing of the mental health unit.
- Ward procedures and policies have been amended to require staff to enter the HDU to record the respiratory rate of sleeping patients, to escalate abnormal findings, and for consultant psychiatrists to develop and communicate individualised plans for patients who refuse physical examination.
- Design work had been undertaken in relation to a new layout for the HDU, as the existing layout and size impacted on the ability of staff to monitor sleeping patients and to respond to an emergency, but no funding had been made available by the time of the inquest.

The coroner supported funding for urgent redevelopment of the HDU.

Coroner's recommendations

The coroner made one recommendation:

1. That the Minister for Health give urgent consideration to funding a redevelopment of the hospital's HDU in order to ensure that two patients can be safely, and sensitively, housed and cared for in the HDU at all times, with the ability for the staff to be co-located in a secure area within that unit in order to facilitate regular visual observations, and furnished in such a way that the area is safe for patients and staff but patients are still able to be accessed for appropriate resuscitation in the event of a medical emergency.

WA health system action

The service assessed that significant works were required for the HDU (one bed) to be able to support safe, high quality and culturally appropriate HDU level care to the Pilbara and Kimberley communities. It was recognised that to meet all the recommendations to function as an HDU, a major redesign and redevelopment of the HDU was required. New designs for the unit have been considered and costed. The functional brief anticipates practical completion in late 2025. The impact of the closure of the unit is continuously reassessed by the service.

References

- Brockliss inquest findings

Further reading and resources

- Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals. Prof MD McHugh et al. The Lancet (May 2021)

Discussion points

- Some jurisdictions set nurse-to-patient ratios. What impact on patient safety and staff wellbeing do mandated staff-patient ratios have? How are those outcomes balanced against budgetary constraints?
- Nurses working on the HDU were reported to conduct visual observations through the window if no other staff member was available to accompany them into the HDU. These types of workarounds are common in many areas of life. What workarounds occur in your workplace? What are the benefits? What are the risks? How can you minimise or mitigate potential risks associated with workarounds?

Home birth after caesarean section

Key Message

- Despite significant improvements in obstetric and midwifery care, pregnancy and childbirth still present risks for mother and baby.

A newborn baby died as the result of severe hypoxic ischaemic encephalopathy secondary to uterine rupture.

His mother lived with her husband in a coastal town and had a history of large loop excision of cervix. Her first pregnancy was complicated by cholestasis, and induction of labour was attempted at 38 weeks to minimise risks to the baby. After two days, she underwent a non-elective caesarean section (NELUSCS) at a regional hospital for failure to progress. She felt traumatised by the experience, frustrated by what she saw as unnecessary interventions, and believed that she would have been able to deliver successfully if she'd been able to carry to term.

Her second pregnancy was planned with the support of the same GP Obstetrician (GPO), who had recently ceased providing intrapartum care. He recommended referral to the regional High-Risk Clinic, given her history and intention to attempt VBAC (Vaginal Birth After Caesarean). At this stage, whilst she was not set against the idea of hospital delivery, she did not want to attend hospital and saw home birth as a possible way to minimise the risk of unnecessary interventions.

She met with a private midwife when she was around 21 weeks pregnant, wanting to have continuity of midwifery care throughout. After meeting with the midwife, she felt very confident about the plan to attempt VBAC at home. She knew of the potential risk of uterine rupture and poor outcome/death and felt confident of the private midwife's ability to respond to any complications during delivery.

She met with a different GPO who would be able to provide back-up for intrapartum care. This GPO also discussed her risk of cholestasis as well as the risks associated with VBAC and home birth. Referral to the High-Risk Clinic was recommended once more but turned down as she did not wish to go to hospital, was aware of the risks of VBAC at home, and was not going to be persuaded to change her plans. The remainder of her antenatal care was provided by the private midwife.

When she had irregular contractions, the midwife checked on her at home. As she was not yet in established labour the midwife went to another appointment, keeping in touch with the father and the back-up midwife with whom she routinely worked. When the midwife returned to check on the mother, it was clear that she was in pain with likely uterine rupture. Transfer to hospital was promptly arranged, with NELUSCS under general anaesthetic performed within minutes of arrival. The baby required resuscitation and transfer to the children's hospital. The mother had a large uterine rupture requiring surgical repair and blood transfusion and was said to be lucky to have survived. It was several days before she was able to see her baby. An MRI at four days of age confirmed that the newborn had severe hypoxic ischaemic encephalopathy and active treatment was subsequently withdrawn.

Inquest findings and comments

The cause of death for the baby was found to be hypoxic ischaemic encephalopathy, secondary to uterine rupture and the manner of death was by way of natural causes.

Comments on care and public health matters

The coroner made comments on a wide range of topics relating to midwifery and obstetric services in WA.

- Home-birthing – this is a common model in many other countries, preferred by some women due to desire for better continuity of care, fears of loss of autonomy with being in hospital with associated real or perceived risks of unnecessary intervention and psychological trauma. WA Health's models of support for home-birthing were discussed, and the risks associated with 'free-birthing' being chosen if no support is available.
- Independent midwife workforce – intrapartum care is not covered by private professional indemnity insurance, only antenatal and postnatal care. Other issues highlighted included workforce numbers vs demand and sustainability of career, establishing relationships with local medical workforce and hospital as back-up.
- VBAC – rates of Caesarean sections in WA are higher than in other places, which may drive higher rates of attempted VBAC. VBAC is no longer an absolute contra-indication for home birth under MP 0141/20 Public Home Birth Policy but requires discussion between parent(s) and consultant obstetrician regarding the level of risk. Parents should understand and accept the risks prior to attempting VBAC, and appropriate support at home and in hospital should be available. The coroner acknowledged that healthcare workers should also feel comfortable with their provision of care aligned to their scope of practice, as 'second victim' harm can be sustained by healthcare workers.
- CTG monitoring and the updated RANZCOG Intrapartum Fetal Surveillance Clinical Guideline (IFS) – CTG monitoring in low-risk labours was associated with a higher rate of caesarean section with no difference in neonatal outcomes.
- Midwife vs Obstetrician – The medical and midwifery views of the birthing process, with the differing goals of optimising physical wellbeing and preservation of life vs a more holistic approach centring on psychological wellbeing and retention of autonomy. The coroner acknowledged that while the role of the coroner is stated as reducing preventable death, there are other types of serious harm to avoid.
- Midwifery and obstetric care in the regional area – The current provision of midwifery and obstetric services in the region was reviewed, and concerns expressed regarding suitability and sustainability, noting the lack of a publicly funded community midwifery program in the catchment area and the limited options available for planned VBAC in the region.

The coroner was satisfied that the newborn's parents were happy with the advice and care provided and that their decision was carefully considered and an informed choice. They went on to have another baby by elective caesarean section.

Coroner's recommendations

No recommendation was made however the coroner made the following encouragement:

> "*for the Health Service to consider what can be done to provide broader community midwifery services and or birthing centre options outside the regional town area and moving into the south-west, as it is clear that the demand for these services is not decreasing, and bringing it within the public health system can only work to ensure a safer system for mothers, babies and health practitioners alike*".

WA health system action

The health service has expanded the Midwifery Group Practice (MGP) model in other WA country regions with an MGP opening in Carnarvon.

In support of improved continuity of care throughout pregnancy and delivery the health service has a policy for private midwives to be credentialed to attend deliveries in a public hospital. This is not currently widely utilised by private midwives.

References

- Baby AM inquest findings

Further reading and resources

- Australian Commission on Safety and Quality in Health Care: Health Care Variation Atlas 2021: Early Planned Births
- Australian Preterm Birth Prevention Alliance

Discussion points

- Avoiding physical risks in obstetric care may often seem to outweigh risk of psychological injury. How can this be navigated?
- Between 2007 and 2017 there was a trend towards increasing rates of elective C-section and early term birth (between 37 and 39 weeks). What are the potential consequences of this? What are the drivers behind this? Should this be addressed, and if so, how?

Inflicted injury

Key Messages

- Recognition of abnormal bruising in children and infants provides opportunity for intervention, potentially preventing escalation of inflicted injuries.
- Children or infants who attend with an injury that might have been inflicted need a full assessment of their physical condition and psychosocial situation.

A four-month-old baby died from head and neck injuries whilst in the care of the DCPFS.

When she was born, her grandmother advised hospital staff of a recent episode of domestic violence that had occurred. Referrals were made to the DCPFS, the hospital's social worker and child health services. No current child protection concerns were identified, and the baby and her mother were discharged.

The baby was taken to five appointments with the nurse at the local child health centre over the next four months, only missing two appointments. On the second last visit, the deceased's mother pointed out a bruise on the baby's cheek, claiming it was sustained when the baby had banged her head against the cot rail. The nurse did not discuss this with their manager or the DCPFS.

The baby's grandmother had also noted the bruises and doubted the mother's explanation but did not want to jeopardise the fragile relationship she had with the baby's parents by reporting her concerns to the DCPFS.

During the final appointment more bruising was evident, and the mother again claimed the baby had continued to bang her head against the cot rail. The nurse expressed concern about the explanation and advised she should report the bruising to the DCPFS, but the baby's mother asked her not to. The bruising was not reported to the DCPFS or to the child health services manager. The mother did not know this, and she later told the child health centre staff that she would be going to a different child health centre in future.

The baby's grandmother contacted the DCPFS a week later, concerned that the baby was unwashed and had more bruising and an apparent friction burn to the neck. Staff from the DCPFS made an unannounced visit to the home and found the house to be dark, cluttered and dirty. Photos were taken of the bruising, and it was decided that the baby should undergo medical review at the local hospital, though no referral was made from the Department to hospital staff. The grandmother was provided with the case worker's personal mobile number, but not the phone numbers for the DCPFS's office or for crisis care.

At hospital, the mother told the triage nurse that they'd been sent by the DCPFS for review. The triage nurse was not convinced by the mother's explanation of how the bruising was sustained, which now included claims that the baby was pulling herself up to try to stand. This red flag was passed on to the shift coordinator, but unfortunately probably not on to the treating doctor. The Junior Medical Officer who reviewed the baby was satisfied with the mother's explanation of the bruises, as was the locum emergency department (ED) consultant who was asked to see her. Neither doctor realised that the DCPFS had been involved, despite the triage notes. The baby was discharged back home with no concerns of inflicted injury.

The next morning the grandmother provided a copy of the discharge letter to the case worker. A short-term safety plan was made with the grandmother asked to check the baby daily until a child protection worker could be allocated. A cot bumper was purchased and given to the family.

Over the following fortnight there were multiple missed opportunities for intervention by the Department, with staff being on leave, and missed calls between the grandmother and DCPFS staff.

Two weeks after the hospital visit, the grandmother visited for the first time in several days. She was informed that the baby had been grumpy for a few days and noticed her to be crying in pain when handled. The mother declined to take her to hospital, and the grandmother decided to call the DCPFS the next day.

Early the next morning the baby was shaken vigorously by her mother and sustained multiple severe injuries. She was taken into care of the DCPFS on arrival at the local hospital prior to being transferred to the specialist children's hospital. The baby later succumbed to the injuries.

The mother was found guilty of unlawful homicide and sentenced to life imprisonment.

Inquest findings and comments

Post-mortem examination revealed multiple fractures of various ages as well as severe head and neck injuries. The cause of death was found to be head and neck injuries and manner of death was unlawful homicide.

Comments on quality of supervision, treatment and care

The coroner noted deficiencies in the care provided to the deceased and her family by the DCPFS and the hospital staff on the first visit. The DCPFS has since developed a High-Risk Infant Policy, accompanied by a training course for staff, with guidance about obtaining review of bruising in non-mobile infants. Changes were also made to risk assessment and intake procedures.

No adverse findings against any staff from the hospital, child health centre, or the DCPFS were made.

Coroner's recommendations

The coroner made three recommendations:

1. That the Western Australian Government considers the undertaking of a regulatory impact review and if appropriate, introduces:
    - An amendment to the *Children and Community Services Act 2004* (WA) to include a duty to report any injuries in a non-ambulant child, in similar terms to the reporting structure for the reporting of sexual abuse of children requirements contained in Division 9A of Part 4 of the *Children and Community Services Act 2004* (WA); and
    - An extension to the current mandatory training program jointly provided by the Department of Communities and the Department of Health – Child and Adolescent Health Service regarding the reporting of sexual abuse of children requirement contained in Division 9A of Part 4 of the *Children and Community Services Act 2004* (WA) to include education on the duty to report any injuries in a non-ambulant child.
2. In order to improve communications between its staff and third parties, the DCPFS should include information regarding the appropriate contact details for its staff (including after-hours) in its High-Risk Infant Policy.
3. In order to provide an appropriate level of support to family members, the DCPFS should prepare a policy document that sets out the practices and procedures to be followed in relation to family members after the death of a child who was in the Department's care.

WA health system action

Health services have implemented a protocol for Clients of Concern Management – when an infant was identified at risk. The Child Health Nurse will also have a monthly review of these cases with a senior staff member.

The role of paediatric injury proformas used across WA health system emergency departments has been considered. The Statewide Protection of Children Coordination Unit (SPOCC) have undertaken a review and analysis of existing paediatric injury proformas and associated escalation systems. Recommendations have been made to improve consistency of proformas and governance across the WA health system.

A review of safety net meetings was conducted and minimum standards for a safety net team have been set. This includes expectations for: the number and expertise of members; the frequency of meetings; record keeping; and, referrals to the Department of Communities and Police.

References

- Baby H inquest findings

Further reading and resources

- Guidelines for Protecting Children (2020). Child and Adolescent Health Service
- National Principles for Child Safe Organisations
- Royal College of Paediatrics and Child Health (UK) - Child Protection Evidence

Discussion points

- How does your service screen for potential inflicted injury? What safety net procedures could be in place?
- How do you support and educate your staff around inflicted injury identification and management of families at risk?
- How do you balance advocacy for a vulnerable infant whilst developing a therapeutic relationship with their family?

Arrest related death

Key Messages

- Organisational and structural racism in health services can contribute to inequity in health outcomes in many ways, including through inadequate cultural safety.
- The rate of incomplete episodes of care can be an indicator of a culturally unsafe service.
- Hospital staffing levels and building design can impact on the level of care provided.

A 39-year-old Aboriginal man died following an altercation with police officers.

The deceased had a history of hypertension, morbid obesity, high cholesterol, methamphetamine use with prior occasions of suspected amphetamine-related coronary artery spasm and drug induced psychosis.

On the evening before his death he was apprehended by police, who were concerned about his apparent erratic behaviour. After having him checked out at the Perth Watch House, including taking blood to test for drugs, he was released from custody and taken voluntarily to an emergency department for further assessment.

He was triaged shortly after midnight, stating that he wanted to see the mental health team. Several nurses and doctors tried unsuccessfully to engage him in conversation, but he left 40 minutes after arrival, saying he wanted to go home and sleep. The police officers with him made unsuccessful attempts to contact his family and offered him a lift home, which was declined.

He was seen on CCTV returning to the emergency department another four times, but it was not clear if he spoke with anyone on those occasions as the triage area was not covered by CCTV. Each time he left 10 – 25 minutes after arriving.

It was possible that none of his four subsequent attendances to ED were noticed by hospital staff, as the triage area is not always staffed overnight, and his last attendance was to the Quick Assessment area before its opening hours. The man had been sighted by some hospital staff members just before 7am, near the hospital entrance, appearing agitated and upset. The staff did not approach him due to concerns for their own safety.

Later that morning he was approached in a carpark nearby by other police officers concerned about his state, who called for an ambulance. After the man stood up suddenly, the police officers feared he would attack them, and engaged him in a struggle, using a Taser initially and then restraining him face down when more officers arrived to help. Restraint was ceased when he stopped struggling and became non-responsive. Resuscitation attempts were unsuccessful.

Inquest findings and comments

Lung congestion, cardiomegaly, and one area of early coronary artery disease were seen on post-mortem, and toxicology revealed methylamphetamine at a level higher than in the blood sample taken at the Perth Watch House, though ‘not especially high’.

Potential factors related to the cause of death were discussed at length including:

- Risk of cardiac arrhythmia from underlying medical conditions including early coronary artery disease, cardiomegaly, hypertension
- Violent exertion leading to raised blood pressure and metabolic acidosis increasing the risk of arrhythmia
- Methamphetamine ingestion, intoxication, ‘excited delirium’, and drug induced psychosis

- Physical restraint and the risk of positional asphyxia
- Taser activation more than five minutes before death.

The coroner concluded that the Taser activations were very unlikely to have directly caused the deceased's death and noted expert opinion that the death could not be directly attributed to the manner and position of restraint.

The cause of death was found to be consistent with cardiac arrhythmia following violent exertion necessitating physical restraint in a man with methylamphetamine effect, known systemic hypertension and morbid obesity. The manner of death was found to be misadventure.

Discussion of matters relating to the actions of the police

Investigations into the incident were conducted by the Homicide Squad and the Police Internal Affairs Unit. Both concluded that there was no criminality in relation to the death and the level of force used was not excessive, and that the attempts to control the deceased were justified and reasonable in the circumstances.

The coroner agreed that the deceased had to be taken into custody for the purpose of an assessment under the Mental Health Act for his own protection and for the protection of the public. He was satisfied that the conduct of the officers was appropriate and in line with their training and police policies. He was unable to conclude that the Taser activations the deceased was subjected to directly or indirectly caused his death, or that positional asphyxia made a significant contribution to the death, though it may have played some role in combination with his intense exertion and methylamphetamine intoxication.

Other than observing that physical exertion would not have occurred if the deceased had not been restrained, the coroner was unable to conclude that the actions of the police caused or contributed to the death.

Discussion of opportunities for improvement - Health

The coroner noted that the Health Service did not have a policy addressing patients who do not wait to be seen after registration at ED. The 'usual practice' was that the senior doctor is informed and then makes a risk assessment as to if a police welfare check is required.

The Health Service policy regarding 'Did not wait' patients was reviewed – the assessment is made by the triage nurse, high risk patients are followed up immediately, escalating to use of the 'Missing or suspected missing inpatient procedure' if needed. Follow up may involve engaging with an Aboriginal health worker or liaison officer.

Whilst the coroner acknowledged that it cannot be known if such a policy or practice would have influenced the outcome for the deceased, a recommendation about this was made.

The coroner noted that Aboriginal Liaison Officers (ALOs) were not available in the hours when the deceased presented to hospital, and that no Aboriginal security officers were employed at the hospital at the time. The coroner acknowledged that the presence of an ALO may not have influenced the outcome. A recommendation about extending the hours that ALOs are available was made.

Discussion of opportunities for improvement - Police

Four mental health co-response teams were available between 1pm and 1am. The focus of the teams is to de-escalate situations involving people with mental health issues, and to ensure the affected person receives treatment and care. Outside of those hours, support from the Mental Health Emergency Response Line (MHERL) or the mental health response coordinator at the

Police Operational Centre is available. The coroner was of the view that the police should review the current availability of these teams, aiming to provide 24-hour availability.

Guidelines from the ANZ Policing Advisory Association have been introduced to assist general service police officers when dealing with people apparently affected by mental health issues.

The need for improved clarity of communication between police and ambulance services was discussed. It was noted that communication skills training is being provided to all general service police officers and that since December 2020, an ambulance service liaison officer has been based at the Police Operational Centre to facilitate appropriate deployments.

Coroner's recommendations

The coroner made six recommendations:

1. In order to promote a patient-centred care approach, the Health Service should consider introducing a policy to deal with patients who do not wait for treatment, similar to the WA Country Health Service policy entitled: Management and Review of 'Did Not Wait' Patients that Present to Emergency Services Policy.
2. To enhance the standard of care provided to Aboriginal people, the Health Service should consider recruiting additional Aboriginal Liaison Officers (ALOs) so as to ensure that ALOs are available outside of business hours on any day of the week.
3. As soon as practicable, and assuming the trial currently underway is positive, the Western Australian Police Force should consider making fastrap leg restraints widely available to police officers and should provide training as to the appropriate use of these devices.
4. The Western Australian Police Force should consider expanding the number of Mental Health Operational Response Teams, so that these specialists can respond to situations involving mental health issues, including those caused or exacerbated by illicit drug use, (e.g. drug induced psychosis) at any time of the day or night.
5. The Western Australian Police Force should ensure that training in relation to Tasers emphasises the importance of avoiding activations to the subject's chest and heart. Further, such training should emphasise the risks involved with repeated Taser activations and remind officers of the very real possibility that prolonged resistance and physical exertion may create an increased risk of the subject experiencing a potentially fatal health event.
6. The Western Australian Police Force should ensure that officers confronting a person exhibiting signs of drug-induced psychosis or related conditions are reminded to treat the situation as a medical emergency and ensure that an ambulance is requested on a priority one basis. Further, all relevant information about the subject's presentation must be communicated in a timely manner to attending ambulance officers.

WA health system action

All health services reviewed 'Did not Wait' policies and procedures to assess their adequacy. Some services have additional strategies including:

- increased waiting room nurse positions
- ALO presence in ED waiting rooms
- increase in social work hours
- identification of patients on webPAS with high risk of 'do not wait' to allow early assessment and follow-up of these patients on re-admission.
- escalation flow charts
- referral to the local Aboriginal Medical Service if the patient leaves and cannot be reached

- direct referral into homecare programs.

References

- Riley inquest findings

Further reading and resources

- 'Dalarinji': A flexible clinic, belonging to and for the Aboriginal people, in an Australian emergency department - PubMed (nih.gov)
- NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool - Aboriginal health
- Clinical Excellence Commission – Diagnostic Report: Understanding contributing factors for Take-Own-Leave in NSW Health organisations (May 2020)
- Australasian College for Emergency Medicine - Closing the Miscommunication Gap
- Australasian College for Emergency Medicine - Traumatology Talks: Black Wounds, White Stitches

Discussion points

- Who defines what culturally safe care looks like?
- Other jurisdictions such as NSW have undertaken work to measure structural racism, and to increase co-design of services with Aboriginal and Torres Strait Islander people. How can cultural safety be improved at your health service?
- Why do some patients leave before they have completed an episode of care? Is this well-understood in your service?

Unexpected death of a teenager

Key Messages

- Whilst it is not always possible to arrive at a definitive diagnosis in the emergency department, a working diagnosis or list of differential diagnoses is essential.
- Time can be a useful diagnostic tool, as illness may progress and become more apparent, or further information may arise.

A 16-year old girl died at home from acute abdominal obstruction secondary to adhesions associated with severe pelvic inflammatory disease, less than a day after being discharged from a regional hospital with no clear diagnosis.

One of seven children, her childhood had been chaotic with episodes of homelessness, alcohol and drug use, and frequent exposure to domestic violence. An allegation of sexual abuse at age eight was reviewed by Police and Communities, but not referred to Health. She was known to be sexually active for several years prior to her death.

She was well known to Police, who made multiple referrals to the Department of Communities regarding her wellbeing however it appears there was little support or intervention from that Department during her life other than initial reviews following referrals.

First hospital visit

The deceased was taken to the emergency department by police when she phoned them, alleging her father had punched her and sat upon her. She complained of pain to her chest and stomach and appeared to be in considerable pain.

She was triaged on arrival, normal vital signs noted, and was seen by a medical officer within 20 minutes of arrival. A small superficial laceration on her head was seen. Abdominal tenderness with voluntary guarding was noted. Bedside ultrasound (FAST) was undertaken with no free fluid seen. Further imaging was not immediately pursued due to concerns for radiation risk given her age. She was given oral analgesia and discharged around three and a half hours after presentation to the care of the police, with instructions to return if her symptoms worsened. The police took her to a friend's house rather than the family home and made another referral to Communities who were subsequently unable to find her. Her father denied the assault to police and Communities.

Aboriginal Medical Service visit

Five days later, she presented to the local Aboriginal Medical Service with a list of issues including the recent assault, new onset per vaginal discharge and requesting removal and replacement of her Implanon® contraceptive implant. She was reviewed by nurses and noted to have BMI under 15, with leucocytes on urinalysis, and otherwise normal vital signs. She gave consent for medical information to be sought from a clinic regarding the Implanon® and from the local hospital regarding her recent presentation. The GP focused on what appeared to be the most pressing issue, the ongoing pain from the recent assault and concerns over safe accommodation and asked her to come back to clinic the next day for review of vaginal discharge and Implanon®. Unfortunately, she did not return for review.

Second hospital visit

She woke, a fortnight after her first hospital attendance, having vomited a lot overnight. She was triaged at the hospital at 09:12 am with abdominal pain and vomiting and was reviewed by a junior doctor at around 10am. Intravenous fluids were started, blood tests performed, and oral analgesia given. Venous blood gas testing showed slightly raised pH, low pCO_2, low calcium, raised glucose and raised lactate. A urine sample tested positive for ketones, tetrahydrocannabinol (THC), amphetamines, opioids and was negative for BHCG. She continued to have pain, vomiting and tachycardia, her abdomen was noted to be soft but tender. Her WCC was 30, with normal creatinine and urea, and mildly elevated CRP. The ED consultant reviewed the deceased and took over her care. Her pain settled and she was able to keep down fluids, so she was discharged after further review with advice to see a GP in 2 days to recheck her bloods, to reduce her marijuana use and to return if she had concerns. It was implied in the inquest that her vital signs were normal at the time of discharge. The consultant ascribed her raised WCC to dehydration as she had no other obvious signs of infection. No diagnosis was recorded, and she was discharged less than four hours after arrival.

She stayed at her sister's house and started vomiting around 4am. She became unresponsive and an ambulance was called around 4:30am. On arrival at 4:42am the paramedics did not detect any signs of life and believed early rigor mortis was present, so resuscitation was not attempted.

Inquest findings and comments

Post-mortem examination revealed acute small intestine obstruction associated with adhesions, acute purulent endometrial infection and left peri-ovarian abscess. Samples from blood, uterus, ovary and peri-ovarian regions were positive for *Neisseria gonorrhoeae*. Expert opinion was that she may have been in septic shock at the time of death. The coroner found that death arose by natural causes.

Comments on quality of supervision and care

The hospital's incident investigation report was reviewed. The possibility of diagnostic fixation with regards to marijuana or other drug use was raised, as well as the absence of a short stay observation unit at the hospital, and the need for improvement in the management of sepsis in high risk patients.

Expert opinion was sought by the coroner regarding the care received. It was noted that the combination of septic shock from gonorrhoea combined with small bowel obstruction complicating severe pelvic inflammatory disease is unusual. It appeared that she was not in shock during her presentation to the hospital, nor showed clear indication of definite sepsis. Admission to an inpatient ward or short stay observation unit would have allowed for further monitoring, repeat blood tests, and better opportunity to ascertain the cause of her pain, ketosis and raised WCC.

The hospital did not have a short stay observation unit, and the WEAT/4-hour rule target was noted to have been likely to have influenced the timing of discharge from the emergency department.

The coroner noted information around emergency department governed short stay observation units provided by the health service and the expert witness, including discharge rates and low reattendance rates for patients discharge from short stay units.

Coroner's recommendations

The coroner heard that the Aboriginal Health Service had made significant improvements to their services in recent years including the employment of a dedicated sexual health nurse, procurement of point-of-care testing equipment for a variety of sexually transmissible infections,

and collaborative work with the local Public Health Unit to coordinate treatment and contact tracing.

The coroner made two recommendations:

1. That the Minister for Health give consideration to funding the creation of a short stay unit at the health campus, which would operate under the governance of the emergency department in a similar way to those already established at other large regional health campuses in Western Australia.

In response to submissions from the deceased's family around cultural awareness training for staff and employment and engagement of Aboriginal people at the hospital, the coroner also made the following recommendation:

2. That the Minister for Health give consideration to funding the employment of Aboriginal Liaison Officers (ALOs) in the emergency department to provide a seven days per week/24 hours per day culturally appropriate liaison service to facilitate better communication between Aboriginal patients and health staff.

WA health system action

The Health Service now has short stay beds on the health campus. A position has recently been filled to undertake work to change the model of service for ALOs to a service-wide, team-based approach with the goal to increase the sustainability and cultural appropriateness of the ALO service.

References

- Miss T inquest findings

Further reading and resources

- Agency for Healthcare Research and Quality: Toolkit for engaging patients to improve diagnostic safety
- Diagnostic Error Learning Resource for Clinicians. Clinical Excellence Commission. NSW
- Tools and Toolkits. Society to Improve Diagnosis in Medicine
- Quality Standards and Resource Toolkit Australian College of Emergency Medicine

Discussion points

- The possibility of diagnostic fixation was raised. What system and cognitive factors increase the risk of diagnostic error? How can diagnostic processes be improved?
- The coroner noted that WEAT/4-hour rule may have influenced the timing of discharge. What are the origins of the 4-hour rule? What problems was it designed to address? What unanticipated outcomes have arisen? What should be done now?

Unexpected death of a mental health service client

Key Messages

- Suicide can be difficult to predict at an individual level.
- Factors related to suicide are often complex and multi-faceted.
- Though all three cases had them same patient outcome, they all had very different journeys leading up to this outcome.

Case 1: Unexpected suicide of a mental health patient

The deceased died aged 38 after going missing from the supported accommodation house where he lived under conditions related to a custody order under s21(a) of the *Criminal Law (Mentally Impaired Accused) Act* 1996.

In his late twenties he was the primary carer for his mother, who had schizophrenia. He became floridly psychotic himself, and murdered his mother, then handed himself in to police. He was initially remanded in custody at the State Forensic Centre where he was commenced on clozapine. At trial 18 months later, he was found not guilty of wilful murder due to being of unsound mind at the time of the crime and ordered to be kept in custody under the Criminal Law (Mentally Impaired Accused) Act until released by an order of the Governor.

His schizophrenia was well controlled on clozapine and was deemed to be in remission a few years later. The Governor issued an order allowing him periods of Leave of Absence of increasing duration. Eighteen months before his death his psychiatrist had recommended that he be able to reside full time at a house providing mental health rehabilitation, and the Mentally Impaired Accused Review Board had prepared a report supporting a conditional release order for the Attorney General.

A few weeks before the deceased went missing his clozapine levels started to fluctuate without explanation, initially becoming too high. Adjustments to the dosage regimen were made, resulting in one sub-therapeutic level the week before he went missing. No behavioural changes were noticed throughout this time, and he appeared his normal self. One day he went out for an approved 8-hour period of leave but did not return as usual later that night. The manager of the house was informed but contact with his case manager and the hospital was not initiated until the following morning, possibly due to misunderstandings about out-of-hours contact processes. The police were eventually contacted late in the afternoon but were unsuccessful in finding him. There were no further sightings of him.

A few years later a Water Corporation maintenance worker discovered his car and remains at a remote site. There was a hose from the exhaust pipe to the front passenger window, keys in the ignition turned on, and an extensive note on the seat containing instructions for his funeral.

Inquest findings and comments

Whilst the pathologist was unable to ascertain the cause of death due to insufficient tissue being available, the coroner was confident in pronouncing the cause of death to be carbon monoxide toxicity and the manner of death suicide. The time of death was determined to be within the week after he was last seen.

The coroner found no evidence that he had been behaving in a way to suggest he was no longer in remission or intending to end his life, but that he had undergone a relapse at the time he wrote the note found in his car due to the contents of the note.

The standard operating procedure for the absence of Leave of Absence patients and the State Forensic Mental Health Service's Absconders without Leave policy that were in existence at the time were reviewed and found to be adequate.

The coroner discussed the delays in notifying the police of his absence but concluded that there was a very real possibility he had already died by the time his absence was first noted.

Coroner's recommendations

The coroner made no recommendations.

WA health system action

The health service reviewed policies related to the case, their compliance monitoring through audit activities and related risk assessments.

Case 2: Methaemoglobinaemia

The deceased died aged 29, from methaemoglobinaemia in association with sodium nitrite toxicity after he ingested a product containing sodium nitrite with the intention of taking his own life. He was subject to a Community Treatment Order (CTO) at the time.

He had been diagnosed with bipolar affective disorder. Following multiple inpatient admissions with deterioration related to non-adherence with medication regimens, he was made subject to a CTO. Due to side effects experienced when he was taking his medication, he was changed over to monthly depot injections of the antipsychotic aripiprazole in addition to sodium valproate and appeared to tolerate this medication regimen well.

There was no record of him expressing any self-harm or suicide ideation or making any attempts at any stage, and no evidence of recreational drug or alcohol use in the last few years of his life. He was seen by his psychiatrist and was reported as being quite well, with good support from his family, employment as a security guard, and no thoughts of self-harm or suicide. Unbeknownst to his family and healthcare team he then purchased 50g of pure sodium nitrite from a supplier in Melbourne.

Ten days later he received his scheduled depot injection at the clinic, and again appeared well with no risks identified. His family report that he seemed okay that evening, but later was found to be unconscious in his locked room. An ambulance was called, and paramedics found a box of sodium valproate in his room, along with a note stating that he'd ingested 25g of sodium nitrite in order to end his life. It was likely that there was confusion around what had been ingested, with emergency department notes mentioning sodium valproate overdose rather than sodium nitrite. He was in asystole on arrival and bedside ultrasound confirmed no cardiac output. Resuscitation attempts by the paramedics and at the hospital were unsuccessful.

Inquest findings and comments

Sodium nitrite has a variety of industrial applications, including in antifreeze and inhibiting corrosion in pipes. In low concentration (6.25%) sodium nitrite is used along with its precursor as curing agents for meat to inhibit bacterial growth and extend shelf life. Curing salts are dyed pink to distinguish them from regular table salt. During the curing process, nitrate is very slowly

converted to nitrite, and nitrite is converted to nitric oxide, which is safe for consumption, though there are concerns over potential carcinogenicity.

Sodium nitrite toxicity occurs through methaemoglobinaemia, where the oxygen carrying capacity of the blood is impaired. Methylene blue can be used as an antidote but must be guided by laboratory testing as it may also cause methaemoglobinaemia. Expert toxicologist opinion was that even if he had been given methylene blue on arrival at hospital, the outcome would not have been changed.

At the time of the death, products containing more than 40% sodium nitrite were regulated under Schedule 7 of the Poisons Standard, meaning they could only be purchased by authorised users. Products containing less than 40% sodium nitrite were regulated under Schedule 6. Sodium nitrate is included in the National Code of Practice for Chemicals of Security Concern.

There were 17 deaths attributable to sodium nitrite in Australia in 2017 and 2018, and the coroner expressed concern over apparent promotion on internet sites as its use as a drug for euthanasia. In 2021, the Therapeutic Goods Administration (TGA) sought public consultation regarding a proposal to reschedule sodium nitrite and in January 2022 preparations of sodium nitrite over 15% were rescheduled to Schedule 7.

Sodium nitrate is naturally present in a wide range of foods, especially vegetables. The World Health Organisation Expert Committee on Food Additives set an acceptable daily intake limit of 5mg/kg. Five percent of ingested nitrate is converted to nitrite by bacteria in the gastrointestinal tract. Ingestion can cause gastrointestinal irritation.

Coroner's recommendations

The coroner made two recommendations:

1. The Therapeutic Goods Administration should consider whether products containing sodium nitrate should be the subject of similar restrictions as those about to be imposed in relation to sodium nitrite, given the similar effect on the human body of both substances.
2. The Therapeutic Goods Administration should consider advising suppliers of products containing sodium nitrite that these products have been widely promoted as capable of causing death in the context of euthanasia and suicide, and suggesting that suppliers take all possible steps to ensure that the sodium nitrite products they sell are intended for legitimate purposes.

The coroner noted that, at the time of delivering his findings, the TGA had published an interim decision of a Delegate of the Secretary of the Australian Department of Health which restricts access to products containing more than 15% sodium nitrite. The proposal was to create a new Schedule 10 entry for sodium nitrite. Exemptions were proposed for closed-loop water treatment systems which are a legitimate industrial use of the substance. This exemption was not thought to compromise the intent of the decision as most reports of self-harm associated with the use of sodium nitrite have resulted from the purchase of small packages of the substance and industrial quantities of sodium nitrite have not been implicated. The final decision (published in January 2022) departed from this proposal, and sodium nitrite was not added to Schedule 10 of the Poisons Standard.

The TGA has not considered scheduling sodium nitrate as it has not found evidence for sodium nitrate misuse.

WA health system action

The CRC discussed the algorithms for online search results with a search for sodium nitrite leading users to other consumables relevant to suicide. A decision was made to contact the

Director of New York Poisons Centre, USA to raise this issue and highlight concerns about the search algorithms, with a view that this concern would be addressed to the American online retailer.

Case 3: Death of an asylum seeker

A female asylum seeker completed suicide by jumping from a sixth-floor balcony.

The deceased had a history of mental health issues prior to her arrival in Australia as an 'unauthorised maritime arrival'. After a month in detention on Christmas Island, she was transferred to Immigration Residential Housing in Perth and subsequently to community detention where she was able to live in her own apartment, other than for a brief period when her residence determination was temporarily revoked and she returned to Immigration Residential Housing.

The man she had travelled to Australia with assaulted her, leading to the breakdown of their relationship and deterioration of her mental health. She attended a Transcultural Mental Health Service (TCMHS) for 10 months until she appeared to have stabilised and was referred to her GP for ongoing care. Her Department of Immigration and Border Protection (DIBP) case manager assisted her in submitting new visa application forms, and in finding new accommodation after the initial assault.

She subsequently became pregnant but did not attend antenatal care until the 25th week of pregnancy. A week later she was admitted to a mental health unit as an involuntary patient, remaining there until after the birth of her son at a maternity unit and a period of time in the Mother and Baby Unit. She found the experience of being an involuntary patient deeply traumatising and her mental health deteriorated during her pregnancy. A referral to DCPFS was made prior to the birth given concerns over her complex mental health concerns, lack of insight, and potential safety of the baby. The baby was taken into care when two months old and the deceased was released from hospital subject to a CTO. Multiple community agencies were involved with providing support for the deceased and her son.

Over the next 22 months she had intermittent periods of custody of her son, with occasional temporary fostering arranged when there were fears for his safety. Her ongoing engagement with psychiatric treatment and adherence to medication regimens was erratic with further hospitalisation and CTO required at times.

Four years after her arrival in Australia the deceased and her son were granted Temporary Protection Visas. On the same day, support workers expressed concern over her ability to safely care for her son. She was taken to hospital for review, where she expressed homicidal and suicidal thoughts. The DIBP and the DCPFS arranged temporary foster placement for her son. She was released the following day as she was deemed to be competent and rational. She resumed custody of her son a week later, only for him to be removed again three weeks later.

The deceased was no longer eligible for DIBP funding after the Temporary Protection Visa was granted, which meant losing access to private psychiatric treatment that had previously been provided, as well as other financial support and accommodation. Transitional support services were provided for 12 weeks to help her find private accommodation. Her GP was encouraged to organise ongoing psychiatric support for her but was unsuccessful despite multiple referrals to community clinics. He eventually managed to arrange for her direct admission to a Mental Health Unit by contacting a psychiatrist who had treated her briefly years earlier when he worked for the Transcultural Mental Health Service. There was confusion regarding plans for follow-up when she discharged herself against advice, and so none was arranged.

In the subsequent months the deceased struggled to engage with DCPFS around the process required for her to be reunited with her son. The repeated handover between community support

agencies and workers also took its toll, as she was tired of having to retell her story to new people so frequently. She struggled with financial matters and ongoing unemployment despite her attempts to find paid work.

A friend was the last person to see her, on a day when she'd been upset about the challenges, she faced around navigating immigration processes and trying to regain custody of her child. She appeared to be in better spirits when he left, but around four hours later she jumped from the balcony of her sixth-floor apartment and sustained unrevivable injuries.

Inquest findings and comments

During her time in Australia, the deceased had interacted with over two dozen separate agencies. As a result, continuity of care was limited, coordination of care was very difficult, and her level of engagement diminished with having to repeat her story multiple times.

The coroner noted that the deceased's transition from the comparatively well-resourced Commonwealth system to State-based care would have been very stressful with a stark drop in available financial, social and health support. It was noted that the demand for community mental health services was such that accessing support would be difficult if the deceased was stable rather than in crisis. The coroner noted that mental health resources are stretched in Western Australia and the staff and clinicians do their best to provide an adequate level of care at a time when demand regularly outstrips beds and staff numbers.

The TCMHS was discussed at inquest. A psychiatrist formerly involved with the service spoke of the need for specialised services for vulnerable people from transcultural backgrounds who found it difficult to access mainstream health services. The TCMHS had subsequently been disbanded when referrals decreased, and patients were diverted to community mental health clinics. Other expert opinion provided was that the closure of the TCMHS had not left any gaps in service as all mental health services provide transcultural services.

Coroner's recommendations

No recommendations were made.

The coroner urged the Department of Home Affairs and the WA Department of Health to work together to ensure better support for people with complex mental health needs when they transition out of detention and into the community, and to ensure that, where possible, there is the option of a client having the same support agency assisting them throughout the process.

WA health system action

The CRC noted that the Multicultural Mental Health Sub Network, established in June 2016 under the governance of the Mental Health Commission (MHC), submitted a report in 2018 identifying multiple gaps in service delivery and accessibility for people with CaLD background, and called for a no-wrong-door, hub-and-spoke model to be introduced. The proposed model was not supported by the MHC.

The MHC provided advice on a number of strategies including the MHC Multicultural Plan which outlines the actions the MHC will undertake to equip the workforce with knowledge, skills and understanding to provide inclusive and culturally sensitive services that meet people's needs, regardless of their cultural background; and working with culturally diverse communities to develop policies, programs and services that meet the needs of people from CaLD backgrounds.

References

- Walsh inquest findings
- Wani inquest findings
- FJ inquest findings

Further reading and resources

- Principles and Best Practice for the Care of People Who May Be Suicidal, Department of Health WA 2017
- A model for an effective and sustainable state-wide Transcultural Mental Health Service for Western Australia. Project Proposal May 2018.
- Multicultural Mental Health Sub Network Establishment Report June 2016
- Therapeutic Goods Administration - Notice of final decisions to amend the current Poisons Standard - sodium nitrite (January 2022)
- Suicide Prevention Australia. Mental Illness and Suicide Prevention Position Statement August 2018

Discussion points

- Can suicide be predicted and/or prevented? What tools exist to assist and how effective are they at the individual level? What are the alternatives?
- What is the role of regulation in reducing the means of suicide? What domains should this extend to (e.g. information about suicide on the internet, supply of potential poisons) and who is responsible?
- Difficulties remain in the provision of care to CaLD communities partly due to their unique requirements. How can we improve the design of services and cultural safety education to better match the needs of our diverse clientele?
- What other barriers to accessing care might still exist? How can they be addressed?

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