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

Progress Report for Health-Related Coronial Recommendations

Biannual Report – August 2023

Executive Summary

Acknowledgements

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

The patients and their families

The Office of the State Coroner, Western Australia

The Office of the Chief Psychiatrist, Western Australia

Department of Health staff, Western Australia

Health Service Providers' Executive Medical, Safety, Quality and Performance Units

All WA health system staff involved.

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

Contents

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACEM	Australasian College for Emergency Medicine
Ahpra	Australian Health Practitioner Regulation Agency
EARA	Environmental Aggression Risk Assessment
ALO	Aboriginal Liaison Officer
ATS	Australasian Triage Scale
ATSI	Aboriginal and Torres Strait Islander
BMI	Body Mass Index
CAHS	Child and Adolescent Health Service
CaLD	Culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Services
CCTV	Closed circuit television (video surveillance)
CCU	Community care unit
CHN	Child health nurse
CLASP	Changes in Lifestyle are Successful in Partnership
CLU	Coronial Liaison Unit
CNMO	Chief Nursing and Midwifery Officer
CRC	Coronial Review Committee
CRRU	Community recovery and rehabilitation unit
CT	Computerised tomography (scan)
CTO	Community treatment order
DAMA	Discharge against medical advice
DMR	Digital medical record
DNA/DNW	Did Not Attend/Did Not Wait
ECHS	Enhanced Child Health Schedule
ED	Emergency department
EDIS	Emergency Department Information System
EMHS	East Metropolitan Health Service
EMR	Electronic medical record
FSFHG	Fiona Stanley Fremantle Hospital Group
FSH	Fiona Stanley Hospital
FTE	Full time equivalent
GRAFT	Graylands Reconfiguration and Forensic Taskforce
hEP	headspace Early Psychosis
HSP	Health Service Provider
HWS	Healthy Weight Service
ICU	Intensive care unit
KEMH	King Edward Memorial Hospital
MHA	*Mental Health Act 2014*
MHC	Mental Health Commission
MHCR	Mental Health Co-Response
MHU	Mental health unit
NAIDOC	National Aboriginal and Islanders Day Observance Committee
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation

NHpPD	Nursing Hours per Patient Day
NMHS	North Metropolitan Health Service
NMTPR	Nurse/Midwife to Patient Ratios
PATS	Patient Assisted Travel Scheme
PCH	Perth Children's Hospital
PMH	Princess Margaret Hospital
PSOLIS	Psychiatric Services Online Information System
PSP	Purchasing and System Performance, Department of Health
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCPA	Royal College of Pathologists of Australia
RkPG	Rockingham Kwinana Peel Group
RPH	Royal Perth Hospital
SCGH	Sir Charles Gairdner Hospital
SECU	Secure extended care unit
SEHA	School Entry Health Assessment
SJGMPH	St John of God Midland Public Hospital
SMHS	South Metropolitan Health Service
SRRU	Secure recovery and rehabilitation unit
SSO	Single sign-on (technology)
TCU	Transition care unit
VDI	Virtual desktop infrastructure
WA	Western Australia
WACHS	WA Country Health Service
WAPF	WA Police Force
WAPHA	WA Primary Health Alliance

Introduction

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

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

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

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

Executive Summary

For the period of 1 January to 30 June 2023 the CRC considered 10 coronial inquest findings (6 for discussion; 4 for noting).

This report details actions taken by the WA health system in response to these inquests along with case summaries. The summaries of these cases are included to provide the reader some context for the recommendations and changes described herein. They are not a full account of events surrounding the deaths. To access the full inquest findings, these are located on the Coroner's Court website at http://www.coronerscourt.wa.gov.au/default.aspx

Coronial inquests with recommendations

This report includes details about the implementation of recommendations of five ongoing cases: Chad Riley, Child AM, Jordan Williams, Morgan Edwards and Quoc Tran. This report also includes information relating to the implementation or consideration of recommendations for three new cases: Lewis Weston, Aishwarya Chavvittupara and Paul Brady.

There was a total of 19 recommendations for the cases in this report that were relevant to the WA health system. Of these 19 recommendations, nine have been duly considered, actioned appropriately by health stakeholders, and marked as complete or closed; and ten recommendations are ongoing at the time of this report. Recommendations are not considered completed until they have been implemented in all applicable services (ongoing recommendations may be partially implemented). Closed recommendations are those that have been duly considered by the CLU and relevant stakeholders, and are either:

- not endorsed with reasonable justification
- have not been implemented as existing systems/processes have been deemed to adequately manage the risk
- the changes are extensive (i.e. part of a large-scale project spanning a number of years) and are a long-term commitment of the WA health system.

Progress will be updated on the ongoing recommendations in the next biannual report.

Where a recommendation is ongoing (i.e. the case has been included in a previous edition(s) of the biannual report), information that was provided in a previous report(s) is included along with new information for completeness. Detailed actions of Health Service Providers (HSPs) are contained within the tables of information at the end of this report, new information is differentiated by using the blue font colour.

RILEY

Chad Riley, aged 39 years, died on 12 May 2017 after being restrained by police officers. Shortly after midnight on the day of his death Mr Riley was taken voluntarily to the Royal Perth Hospital (RPH) Emergency Department (ED) by Police. Mr Riley was triaged, and he requested to speak with the pysch team. Attempts to engage Mr Riley in conversation were made by several nurses and doctors with no success. Mr Riley did not wait to be assessed by a doctor in the ED. Over the next seven hours Mr Riley was seen on CCTV returning to the ED on a further four occasions each for a short period of time before leaving again and did not wait to be triaged. At the inquest it was noted that these four attendances may have gone unnoticed by ED staff. Shortly prior to midday Mr Riley was approached by Police in East Perth who were concerned that he required medical care and called for an ambulance. Mr Riley suddenly became engaged in a struggle, and he was restrained by police officers in a prone position. Whilst being examined by a paramedic Mr Riley stopped breathing, resuscitation was commenced, he was taken by Ambulance to the RPH ED however could not be revived.

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

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

The WA Country Health Service (WACHS) *Management and Review of 'Did Not Wait' Patients that Present to Emergency Services Policy* outlines the process of management and review for those patients who did not wait for treatment after triage and the WACHS duty of care for the presenting patient. The EMHS has released a *EMHS Did Not Wait Policy*, which is accessible to staff via intranet.

In the absence of relevant policy, HSPs advised in February 2022 that established processes were in place to identify and follow up patients who do not wait and confirmed further actions had been identified to strengthen these processes. In February 2022, the South Metropolitan Health Service (SMHS) expressed an intent to develop a do not wait policy; the North Metropolitan Health Service (NMHS) were undertaking further liaison to identify if a policy will benefit NMHS patients and have proceeded with developing the policy; and the Child and Adolescent Health Service (CAHS) currently had a work instruction and were formalising a procedure based on audit findings and the WACHS policy.

Health Service Providers advised of several further mechanisms to monitor patients who do not wait which included indicators in the Health Service Performance Report. In addition to this, EMHS advised a combined discharge against medical advice and did not wait action plan was developed, outlining a 12-month strategy to reduce both types of events. WACHS advised several strategies that support the implementation of the did not wait policy, including flow charts, referral to the local Aboriginal Medical Service if the patient cannot be reached, direct referral into homecare programs, increased waiting room nurse positions, ALO presence in ED waiting rooms and increase in social work hours. Strategies also include identification of patients on webPAS with high risk of ‘do not wait’ to allow early assessment and follow-up of these patients on re- admission.

In response the recommendation addressing the availability of ALOs, EMHS advised that an additional 5.1FTE ALOs have been recruited and EMHS is aiming to recruit an additional 0.8FTE for mental health services at Armadale Kalamunda Group. Following a review assessing where the additional ALOs would be most beneficial, the additional resources have

been allocated accordingly. These include additional resourcing to a range of afternoon, evening and weekend services. In addition, EMHS have developed a suite of informative videos for Aboriginal people to be viewed in ED waiting rooms, free to air patient channel (TV) and outpatient areas. The Welcome to Country and Discharge Against Medical Advice (DAMA) videos were launched in NAIDOC week July 2022. These animation videos use subtitles and language translation.

Other HSPs advised that they currently provide a Monday to Friday ALO service, with only some hospitals providing an out of hours service with coverage to the ED. One Hospital is currently extending this service to the ED and is seeking to identify ways to increase access to seven days. Another hospital advised that an on-call service was trialled with coverage on weekdays from 9:00am to 5:00pm, however the service ceased due to minimal uptake and maintaining staffing for the on-call service. Another HSP advised they will monitor the demand for ALO services and consider providing services outside of working hours if required.

CRC members observed the link to the previous coronial inquest into the death of Levi Shane Congdon and use of the term excited delirium. Members also observed the link to the Victorian and New South Wales coronial inquests which recommended that the term excited delirium be removed from all police training material until such time that it is recognised by the relevant Australian Colleges. It was determined that advice should be sought from the colleges representing pathologists, emergency physicians and psychiatrists to determine their position on the use of the term.

- The Royal Australian and New Zealand College of Psychiatrists (RANZCP) advised that the college publishes a range of statements and guidelines to inform the work of its members, and that none of these publications make specific reference to excited delirium, nor is it included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases 11th edition (IDC-11). The RANZCP is supportive of ongoing training for police and other relevant professionals in the management of people with agitation and behaviour disturbance, and that given the term excited delirium is not used within guidelines for psychiatrists it should not be the primary focus of any police training. The RANZCP suggested that police training should include understanding of the terminology commonly used for people suffering from this condition, in a way that communicates the emergency nature of treatment required. Terminology commonly used includes acute behavioural disturbance or agitated delirium.
- Similarly, the Royal College of Pathologists of Australasia (RCPA) advised that the College does not have a Position Statement on the use of the term excited delirium. The RCPA provided further advice that police training should include the dangers of physical restraint especially in potentially intoxicated or agitated persons.
- The Australasian College for Emergency Medicine (ACEM) confirmed that, at present, the term excited delirium is not a term that its members would see being used within the ED setting. The term ‘acute severe behavioural disturbance’ is more commonly used by emergency physicians. This is a clinically defined syndrome which is broadly used by health professionals, and is the term used in clinical guidelines and protocols developed and referenced by ACEM’s members. The syndrome can be caused by a variety of underlying medical conditions and when a patient experiences acute severe behavioural disturbance, it is a prompt for clinicians to seek, and treat, any underlying conditions.

The advice of the three Colleges was included in correspondence to the Police Commissioner in relation to the Congdon and Riley inquest findings. This correspondence expressed concerns about the use of the term ‘excited delirium’ when communicating with officers and clinicians across the health sector. The response indicated that the relevant coronial findings had been reviewed within the WA Police Force and significant work had been undertaken to consider the

use of the term excited delirium. This included liaison with the St John Ambulance to increase the collective understanding of each organisation's terminology and processes; and advising WAPF personnel on the need to use plain language to describe symptoms wherever possible. The WA Police Force indicated an ongoing rationale for continued use of the term excited delirium, specifically existing training and education of officers which teaches the importance of managing the medical emergency as well as the behaviour in dynamic situations.

Recommendation two, pertaining to recruitment of ALOs was deemed completed with the last progress report (February 2023). With the implementation of the EMHS Did Not Wait Policy, CRC members have agreed that recommendation 1 has now also been deemed actioned and deemed completed.

CHILD AM

Child AM, aged 3 years 11 months, died on 4 September 2015 from bronchopneumonia in an infant with obstructive sleep apnoea. Child AM was born in a remote community in the East Kimberley. She was evacuated from her community multiple times with obesity-related health issues, spending time in Broome Hospital, Royal Darwin Hospital, Halls Creek Hospital and Princess Margaret Hospital (PMH). Her final admission to PMH to monitor her respiratory conditions and introduce controlled weight loss programs was prolonged, after which time she was discharged into the care of a foster carer. She had also been referred to the Changes in Lifestyle are Successful in Partnership (CLASP) Service, which has since been replaced by the Healthy Weight Service (HWS) at Perth Children's Hospital (PCH). Two months after her last admission to PMH, Child AM died unexpectedly at home. She had fallen asleep on the floor in front of the television as was common for her and, when her foster carers tried to move her, they found that she was unresponsive. Resuscitation efforts were unsuccessful.

The coroner made two recommendations related to the HWS at PCH including to introduce an outreach service and for the service to be culturally appropriate for Aboriginal families.
The CRC has reviewed these findings and made enquiries with the relevant stakeholders.

Following receipt of advice from the CAHS, advice was sought from the WA Country Health Service (WACHS). CAHS advice indicated that the HWS is a family-based lifestyle and weight management program at PCH. Children who meet the eligibility criteria are required to regularly attend PCH for a period of 6-12 months. Children not meeting the eligibility criteria or families unable to commit to the requirements for attendance are referred to alternative services. CAHS opined that extensive programs with significant face to face requirements cannot be delivered via outreach. Further, CAHS acknowledged the limitations in service delivery models, as CAHS does not have a state-wide remit for paediatric services and has no oversight of paediatric services provided by other HSPs including WACHS. However, successful collaboration examples between CAHS and WACHS through established care pathways that enables tertiary care for country children were observed.

Early consultation occurred between CAHS and WACHS to determine how best to approach children with severe obesity in the regions with initial discussions suggesting that upskilling of local health care providers to deliver similar but not identical programs to the HWS would be the most cost effective and easiest to resource. Local demand and ability to maintain suitable staffing were acknowledged as limitations.

CAHS acknowledged the increasing need for the WA health system to deliver services that are culturally appropriate across Aboriginal and Culturally and Linguistically diverse (CaLD) communities. However, it was suggested that for a program to be applicable across the whole state and be successful, it must be tailored to and led by the local Aboriginal community and their Elders and capacity to do so is limited by resources and difficulty in creating and sustaining multiple different versions of a program. Following review, CAHS considered that other avenues existed to better engage Aboriginal families accessing the HWS through involvement with the CAHS Aboriginal Health Team and WACHS Aboriginal families.

WACHS has established and is leading a project working group which will develop a model of care for the management of children living in Country WA with high Body Mass Index (BMI) and provide recommendations for operationalising the model. Working group membership includes representatives from CAHS Perth Children's Hospital (Endocrinology) and WACHS (Population Health, Dietetics, Paediatrics and Health Weight). A draft model has been developed and a broader consultation process will be conducted with relevant stakeholders to inform the development of a shared care model that is also culturally safe. The key focus for the working

group is currently to ensure a service delivery model that provides equity of service provision across all seven regions.

While this work progresses, standardised protocols exist within the WACHS Health Country Kids program for assessment of growth for children aged 0 to 5 years with key checks by Community Health Nurses (CHNs) through the Universal Child Health Schedule and as part of the School Entry Health Assessment (SEHA). Child Health Nurses routinely monitor weight and body mass index (BMI) data and record it in the WACHS Community Health Information System as part of the child's clinical record. This is accessible throughout WACHS by any authorised clinician involved in the child's care. If concerns about weight are identified during a universal or targeted assessment, CHNs firstly work with parents and carers to promote and strengthen healthy lifestyle habits for all family members. Where additional support or resources are required, the CHN may refer to specialist services or programs.

Progress for the recommendations will be updated in the next biannual report.

WILLIAMS

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

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

The CRC reviewed these findings and discussion included advice from WACHS about the progress made against the three recommendations. Members noted that at the time of the June 2022 CRC meeting, the pre-tender estimates process had been completed and the tender for fencing works had closed with work anticipated to be completed by the end of August 2022. WACHS advised members that they had formally corresponded with the Office of Rail Safety and ARC Infrastructure to bring the matter of safety of railway fencing to their attention.

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

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

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

Regarding the coroner's recommendations, WACHS has advised that practical completion of the installation of a new boundary fence was achieved in June 2023. In November 2022, no response has been received from the Office of Rail Safety nor ARC Infrastructure following WACHS' formal correspondence advocating for the upgrade to fencing to restrict access to railway tracks.

The CRC members agreed that all recommendations have been considered and have been closed or completed.

EDWARDS

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

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

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

The SMHS advised that the Fiona Stanley Hospital (FSH) Discharge from the Emergency Department Guideline has been reviewed by the ED Head of Department with amendments that address both recommendations. The guideline states that, for vulnerable groups, such as those with impaired communication or impaired capacity to be involved in disposition decision making, discharge decisions should be made with caution, particularly when a discharge diagnosis has not been secured. In these situations, a lower threshold for admission for observation should be considered. Where patients are being discharged to a nursing home or another version of residential care, the guideline ensures that a discharge letter is provided to the transport team and that the junior medical officer has notified the facility. The discharge advice should include specific information about the clinical concerns to be monitored by care staff on discharge and the expected responses to a change in the patient condition. A discharge Transfer Checklist will be completed and sent with the patient. RGH has adopted the FSH guideline making them specific to their context.

Coronial Review Committee members have agreed that both recommendations have now also been actioned and deemed completed.

TRAN

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

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

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

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

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

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

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

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

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

The MHC informed the CLU in May 2023 that it has simplified the naming conventions of these units. SECUs are now known as Secure Recovery and Rehabilitation Units (SRRUs), and CCUs and Transition Care Units (TCUs) are now known as Community Recovery and Rehabilitation Units (CRRUs). Though, the operating names of the existing services may continue to be SECU/CCU/TCU.

The MHC advised the CLU about:

- a 20-bed facility in Orelia known as Living Well – Mental Health Community Care Unit. The service is funded by the MHC and is delivered in partnership by Richmond Wellbeing and the SMHS. The CRRU initially commenced as a day program in July 2022 and the residential services commenced in November 2022.
- The Bidi Wungen Kaat Centre is a 40-bed adult residential service for mental health consumers located in St James, delivered by the EMHS since late 2022. Known as the St James TCU, this CRRU provides contemporary staged recovery support for people experiencing mental health issues, offering transitional care between the hospital setting and community living.
- The EMHS' John Milne Centre is being rebuilt at Bentley Hospital and will be a contemporary 12-bed SRRU.

The GRAFT was appointed by Cabinet in January 2021 to oversee the planning for the future of the Graylands Hospital and Selby Older Mental Health sites and services. Based on robust demand modelling to 2031-32, GRAFT has provided Government with a clear picture of what inpatient and community bed-based services are needed to rebalance the mental health system. This includes a mix of SRRUs, CRRUs and Forensic CRRUs.

In relation to lobbying the MHC for planned SECUs (now SRRUs) and CCUs (now CRRUs) to be operation as soon as practical, CRC members agreed that the coroner's recommendation has been considered actioned and completed.

WESTON

Lewis Henry Mark Weston died, aged 22 years, during a period of transition between mental health services. He was subject to a CTO under the care of Headspace Osborne Park. Following his family's relocation to another catchment area, his care was transferred to Bentley Community Mental Health Clinic, which included transfer of the CTO. Risk assessments conducted by Headspace and Bentley found that he was at low risk. Police were notified when two suicide notes were found in his room and his car was missing. Police found him hanging in a nearby park later than morning, too late for any resuscitative efforts.

One recommendation was made relating to a reciprocal sharing of information between the clinical information database PSOLIS (Psychiatric Services Online Information System) and the clinical databases of non-government organisations (NGO) that provide mental health services to the community.

The CRC reviewed these findings and noted that the Department had provided advice to the coroner at the time of the inquest. The Data Steward for the PSOLIS (Psychiatric Services Online Information System) provided the coroner with advice that the Department of Health would consider sharing information from PSOLIS with mental health clinicians working in NGOs where the use of the data is consistent with the lawful purposes permitted under the *Health Services Act 2016* as prescribed in the Department's Information Access, Use and Disclosure Policy. Following CRC discussion this advice was confirmed with the appropriate stakeholder.

The current Data Steward for PSOLIS has communicated in principle support of the coroner's intention that the Department be proactive and invite relevant NGOs to participate in reciprocal sharing of information and to organise the implementation of any such arrangements. A pilot programme will assess the technical and operational feasibility of sharing information from PSOLIS with mental health clinicians working in NGOs.

The Department is currently working with headspace Early Psychosis (hEP) as part of this pilot programme. The pilot will provide mental health clinicians working in hEP with read-only access to assess the technical and operational feasibility of NGO access to PSOLIS. Once technical and operational feasibility has been assessed, the Department will consider the next steps required to proactively invite NGOs across the state to apply for read-only PSOLIS access.

As per access requirements for all health information, entities must ensure appropriate governance models are in place to control, monitor and audit health information, use and disclosure. The method of PSOLIS access will be negotiated with Health Support Services following the pilot. Any further access arrangements or technical development to support the reciprocal sharing of information between PSOLIS and the clinical databases of NGOs will be considered following a review of the pilot programme.

On the understanding that the pilot programme has been implemented; the results of which will inform further rollout of PSOLIS access, the progress of this recommendation will be updated in the next biannual report.

CHAVITTUPARA

Aishwarya Aswath Chavittupara died, aged 7 years, after presenting to the PCH ED. Aishwarya was taken to the ED by her parents after she became increasingly unwell at home. Aishwarya was allocated ATS 4 at triage, though no vital signs were measured at the time. Her deteriorating condition was not immediately detected despite concerns being raised by her parents and Aishwarya being seen by clinicians whilst in the waiting area. Aishwarya was moved momentarily to a bed in the assessment area, and then to the resuscitation bay when it became clear how unwell she was. Aishwarya went into cardiac arrest shortly after. Despite extensive resuscitative efforts, she could not be revived.

Five recommendations were made relating to the implementation of nurse/midwife to patient ratios in public hospitals, implementation of a supernumerary resuscitation team at PCH ED, safe harbour provisions protecting nurses from Ahpra (Australian Health Practitioner Regulation Authority) investigation, prioritisation of funding for the EMR (Electronic Medical Record) program, and timeliness of observations to be taken at triage when children present with gastrointestinal symptoms.

The CRC reviewed these findings and discussion included an overview of what progress had been made to address some of the recommendations. Overall, members supported a broader scope for implementation of recommendations two and five across the system, and further enquiries will be made with relevant stakeholders.

With regard to recommendation one, the State Government announced in late 2022 that it was committed to transitioning to Nurse/Midwife to Patient Ratios (NMTPR) from Nursing Hours per Patient Day (NHpPD) within public health clinical inpatient areas as soon as possible. Following an announcement by the Minister for Health in April 2023, PCH ED was first to transition to NMTPR in July. Transition to nursing ratios commenced in PCH ED on 17 July 2023. Transition will occur over a six-month period and will be supported by the PCH ED Nursing Ratios Working Group, as well as implementation, communication and operational plans which are reviewed and updated regularly. Additionally, a workload escalation procedure has been developed as a mechanism for staff to escalate workforce concerns during the six-month transition period.

CAHS has advised that implementation of the full complement of a supernumerary resuscitation nursing staff (recommendation two) will be staged to maintain an appropriate number of experienced senior nursing staff on every shift within the [PCH] ED, which is critical to patient safety. From 1 July 2023 PCH is working towards having four supernumerary resuscitation nurses per shift on the roster. Every effort is being made to expedite implementation, whilst maintaining an absolute focus on patient safety, and safe nursing skill mix on a shift-by-shift basis.

The Department of Health has considered the introduction of safe harbour provisions to protect nurses in the event of an adverse event in the context of known risks having been identified and not rectified by their employer. The information currently available on this concept is limited, with only two overseas jurisdictions known to be operating with some form of safe harbour legislation. The Department of Health believes that appropriate protections are afforded under existing legislation and policy and does not believe that such provisions are required at this time.

In relation to the coroner's fourth recommendation, WA Health is committed to a full implementation of EMR, which is key to modernising health care in WA as recognised and supported by the Sustainable Health Review. To manage the significant complexity of rolling out an EMR, the project is being undertaken through a phased and prioritised approach. Stage 1 of the strategy is implementation of the Digital Medical Record (DMR) to build capability and deliver early benefits, followed by Stage 2 which will be the roll out of a state-wide EMR. Through the 2023-24 Budget, the State Government has prioritised funding for Stage 1 of the EMR with an additional $99.4 million investment, bringing total investment to date to $156.7 million. Through

this investment, DMR rollout across WA is progressing well with four of WACHS seven regions now using the DMR. PCH is well progressed for implementation.

CAHS has advised that a work instruction introduced in December 2022 requires that vital observations are to be taken within 30 minutes of triage except for some patients with minor injury, and some mental health/behavioural/social patients.

Recommendation three was considered but not supported and has therefore been closed. On the understanding that the implementation of an EMR is a long-term commitment for the State Government and WA Health, members agreed that recommendation four has been deemed closed. Further enquiries will be made with relevant stakeholders and progress of ongoing recommendations one, two and five will be updated in the next biannual report.

BRADY

Paul James Brady died, aged 35 years, after jumping from a ledge of the third floor of a building where he resided. He had been seen by a member of the public shortly before jumping, who contacted police with concerns for his welfare. Police and the Midland District Mental Health Co-Response (MHCR) team were dispatched, along with St John Ambulance and Department of Fire and Emergency Services. Police arrived promptly at the scene shortly before he jumped, however, they were unable to persuade him to sit. He suffered extensive injuries when he jumped and was unable to be revived.

Three recommendations were made relating to ongoing funding of the MHCR, including external funding to support expansion, and that work continues on the planning of the MHCR in regional areas.

The CRC reviewed these findings and members expressed concerns about the change to the operational model for the MHCR since it was established. In particular, the perceived decrease in the role of the mental health clinician in de-escalation. Members agreed that concerns from the Ms L matter would be raised with the Mental Health Commission in conjunction with seeking advice about the three recommendations from the Brady findings.

Enquiries will be made with relevant stakeholders and advice pertaining to these three recommendations will be included in the next biannual report.

Coronial inquests with no health-related recommendations

In addition to health-related coronial inquests with recommendations, the CRC also considers health related coronial inquest findings where no recommendation is made for the WA health system. The CRC considers such inquests to identify opportunities for WA health system learnings and to recognise where there is a need to implement improvements across the system. This section outlines any WA health system action taken, as well as system improvements that were noted by the CRC to have been implemented since a death occurred (i.e. not in direct response to the death).

Between 1 January 2023 and 30 June 2023, the CRC considered the following new coronial inquests where no health-related recommendations were made: Painter, Ms L and Taulelei. Following CRC members' discussion, enquiries were made with relevant stakeholders in the matter of Ms L. No actions were taken following discussion of the Painter or Taulelei findings.

MS L

Ms L died, aged 27 years, as a result of multiple injuries after she stepped off the roof of a multi-story apartment building. Police officers had been speaking to her shortly before hand, following up on a missing person report initiated by family in Europe and her ex-boyfriend who had been unable to contact her, and were concerned about her worsening depression. She had denied any self-harm or suicidal ideation and had not appeared distressed. After she excused herself to go to the toilet, she made her way to the rooftop and despite police pleas to step back from the edge she stepped off the edge, falling 30 storeys. The coroner found that death occurred by way of suicide.

No recommendations were made by the coroner in relation to the death of Ms L. However, the coroner referred to statements made by a police officer, which were of interest to the CRC. A WAPF officer advised the Coroner's Court that "the MHCR teams had become secondary responders rather than primary responders, because of unspecified 'changes in safety legislation' and 'a mitigating strategy to facilitate the safe deployment of the clinician to police managed tasks'". The officer also advised the Court that "at present the MHC, in collaboration with the HSPs and WAPF (are) considering options to revitalise/reposition the MHCR program".

When the Department of Health's Coronial Review Committee (CRC) considered the coronial inquest findings for Ms L in February 2023, HSP members were not aware of work being undertaken to revitalise or reposition the MHCR program. When discussing the Paul James Brady findings at the June 2023 meeting, members expressed concerns about apparent changes to the MHCR's operational model since it was established. Enquiries will be made with the Mental Health Commission in order to better understand the current policy and practice for the deployment of a MHCR.