



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

From Death We Learn 2011

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The Health Services' Safety, Quality and Performance Units

All medical and nursing staff involved in the reporting and review of death

The patients and their families.

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

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From Death We Learn and coronial inquest finding documents identified in this text can be downloaded from the following website:

http://www.safetyandquality.health.wa.gov.au/mortality/coronal_liaison.cfm

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Coroner's foreword

This publication is an important outcome of the very positive interaction which has been taking place for a number of years between the Office of Safety and Quality in Healthcare¹ and the Coroner's Court.

Families whose loved ones have died unexpectedly following medical treatment often struggle to come to terms with the circumstances surrounding the death. For these families it is often extremely important for them to have an expectation that the death of their loved one will result in changes which could prevent similar deaths occurring in the future.

It is hoped that the summaries of cases which have come before a coroner will assist in the treatment of future patients.

While most of the focus of these cases is on the treatment of patients, I wish to highlight for readers the fact that one of the reported cases raises issues which may be of importance to the safety and wellbeing of treatment providers.

The death was of a Patient Care Assistant working night shifts who died in a single motor vehicle accident. It appeared that the accident was caused by driver fatigue.

In that case expert evidence raised concerns about the safety of all health professionals who work shift work or who work long hours and then drive home. It was pointed out that health professionals usually work in bright lights, on their feet, in circumstances antagonistic to awareness of fatigue. These health professionals face a very changed environment when they go to drive home in a car where they sit hardly moving, relaxed and subject to gently motion within the vehicle. These factors together contribute to increased risk of fatigue-caused motor vehicle crashes.

That case highlighted the need to be aware of fatigue issues and to be alert to the particular dangers faced by health professionals in this context.

Before health professionals can provide the best quality of care to their patients, they must first look after themselves and this sad case has highlighted that important fact.

It is hoped that the comments and recommendations made in a medical setting in these cases will be of assistance to you and may prevent similar deaths from occurring in the future.

Mr Alastair Hope
WA STATE CORONER

¹ Historically, the Coronial Liaison Unit has resided within the Office of Safety and Quality in Healthcare, Performance Activity and Quality Division. The Coronial Liaison Unit is now situated within the Patient Safety Surveillance Unit; also within the Performance Activity and Quality Division.

Editorial

Investigation of deaths provides a valuable insight into the way our health system works. It remains important for the health system to share lessons and learn from unexpected or preventable deaths in order to improve health care services for the future.

This is the sixth edition of From Death We Learn.

A number of cases that have undergone a coronial inquest have been reviewed with particular issues highlighted. This year we draw attention to the importance and difficulty in maintaining physical health in people with mental health problems (Barnes inquest) and the role of medical practitioners in the administration of unproven therapies (Operation Lantana).

All hospitals and health services are encouraged to use this document to raise awareness among health professionals of the lessons learned from unexpected or preventable deaths.

The Editors:

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Introduction to the Coronial Liaison Unit

The Coronial Liaison Unit (CLU) is situated within the Patient Safety Surveillance Unit, Performance Activity and Quality Division, at the WA Department of Health. Currently the unit consists of two clinical advisors (a Consultant and a Senior Registrar) and a Policy Officer. It was established in 2005 as a health initiative to improve communication between WA Health and the Office of the State Coroner. The CLU facilitates the allocation of health related findings from coronial inquests for implementation in hospitals and health services.

The CLU reviews all public inquests that have a medical aspect to them and places the recommendations via the Chief Medical Officer with the appropriate area within WA Health. Expert advice and comment on the recommendations and action taken to improve patient safety in response to the inquest findings, are fed back to the State Coroner in a biannual report.

The CLU also receives non-inquested² case reports from the Coronial Medical Advisors for the purpose of quality improvement. If there are aspects to these cases which are of concern, the CLU raises these issues with the appropriate clinical director from the relevant hospital/health service and seeks assurance that the death has been reviewed in a quality improvement environment.

For the purpose of quality improvement, the Coronial Ethics Committee allows the CLU access to provisional post mortem reports to assist clinicians to undertake mortality reviews. Where clinicians require post mortem findings to effectively review a death, an application for the preliminary results can be made via the CLU.

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

² Deaths which are reportable to the Coroner, that do not require a public inquest, but may have an aspect which needs investigation or review by the health system.

Introduction to inquested cases

While under the *Coroners Act 1996* every regional magistrate is contemporaneously a coroner, the majority of inquests are held by the State Coroner Mr Alastair Hope; Deputy State Coroner Ms Evelyn Vicker; and Coroners Mr Dominic Mulligan, Mr Jeremy Packington, Mr Barry King, and Mr Peter Collins.

In Western Australia approximately 2,650 deaths were reported to the Office of the State Coroner in the 2011/12 year, with approximately 1,900 being deemed Coroner's cases (reportable deaths in accordance with the *Coroners Act 1996*). Approximately 750 deaths were subsequently dealt with by the treating doctor by issuing a death certificate recording the cause of death. These deaths are not accepted as coronial cases. The remainder become coronial cases and in 2011/12, approximately 100 deaths were subject to public inquest.³

WA Health's responses to coronial recommendations arising from public inquests have been included in this report where the timeframe has allowed a response to be formulated prior to publication.

These public inquests provide valuable lessons to be learnt from the dead to protect the living.

³ Office of the State Coroner (2012) Annual Report 2011-2012

Mental illness and physical disease

Key messages:

- Chronic mental illness and associated lifestyle choices can lead to increased risk of physical disease.
- Mental health problems can also decrease compliance with treatment of physical problems.
- Mental health clinicians should maintain a holistic approach to their patients and ensure that both mental and physical needs are met.

A 50 year old woman with a long history of chronic paranoid schizophrenia was admitted to an inpatient psychiatric ward at a public hospital with persecutory delusions and marked impairment of insight and judgement. Her medical history included polycystic ovarian disease, morbid obesity, hypothyroidism, glucose intolerance, heavy smoking, longstanding poor mobility (wheelchair dependence for seven years), asthma, pressure ulcers on her buttocks and ulcers on her feet.

She was reviewed by a doctor after complaining of 'flu-like symptoms' and was prescribed oral antibiotics. Seven days later she was found unresponsive in her bed. Resuscitation efforts were unsuccessful.

The Coroner found that:

Death arose from natural causes and occurred as a result of acute heart failure in association with acute on chronic obstructive airways disease (recent influenza A infection), focal coronary atherosclerosis and morbid obesity.

The Coroner commented that:

- The quality of the deceased's supervision, treatment and care whilst she was an inpatient, appears to have been generally good.
- The deceased had received high quality care from her psychiatric team.
- Whilst medical records for the period immediately prior to her death were lacking or deficient, it appears that she received medications and treatment as required.
- It was concerning that the deceased's medication chart recorded medications being given at 8:00am on the morning of her death when she had been found dead at 7:45am.

The Coroner recommended that:

The Hospital take steps to ensure that medication charts accurately reveal the giving of medications and that the charts not be written up in advance or at a time when the medications have not been provided to patients.

WA Health action:

Following this death the psychiatric hospital made a number of changes in procedure:

- hospital policy was updated to reflect the need for entries to be made in the integrated progress notes on a daily basis and not only on an event basis
- development of a physical care plan for mental health patients
- establishment of physical care working groups to deal with the physical care of mental health patients.

WA public hospitals have undertaken the following actions in response to the findings of this inquest:

- policies will incorporate standards around recording of administration of medication and times
- medical records audits will examine recording of medication
- education packages will be developed to inform staff of policy changes.

Additionally, on a system-wide basis, guidelines to help people with mental health problems receive better medical assessment and treatment for their physical health have been developed. The guidelines aim to help mental health clinicians and primary care clinicians take a more holistic approach to the care of patients with mental disorders.

Reference: [BARNES Inquest](#)⁴

⁴ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Barnes_finding.pdf

Infant death in a rural hospital

Key messages:

- Recognising abnormal vital signs is of paramount importance, particularly when assessing paediatric patients.
- Referral for medical review must occur where indicated.
- All staff should ensure that they are aware of relevant guidelines pertaining to their area of practice.

The deceased was a three month old baby who had been born prematurely with congenital heart disease and underwent surgery in Perth. He was then transferred to a regional hospital and subsequently discharged home with his parents who resided in a rural community.

A week later he was taken by his mother to a rural hospital with a fever. His observations there revealed pyrexia of 40.2 °C, a pulse of 192 beats per minute and respiratory rate of 88 breaths per minute. He was reviewed by a nurse and discharged; a doctor was not consulted.

He was brought back the following morning and was pronounced deceased.

The inquest identified that:

- The deceased died as result of natural causes in circumstances where it is not known whether, with medical intervention, a different outcome would have resulted.
- Although observations taken at the hospital constituted a medical emergency and immediate action should have been taken to contact a doctor, this was not done.
- There were overwhelming reasons for immediate notification of the deceased's condition to a doctor.
- Evidence was given at the inquest regarding policies, procedures and guidelines in place and available to staff at the hospital. In particular, the Coroner noted a document in laminated form headed, "Patients to be notified to the doctor by A&E Triage Nursing Staff" that included, "all neonates and infants up to the age of 6 months" and "all children up to the age of five years with pyrexia".

The Coroner concluded that:

Death was consistent with cardiac arrhythmia associated with surgically corrected congenital heart disease. It was recognised that this did not totally explain his preceding deterioration.

The Coroner recommended that:

Any list of patients requiring to be notified to a doctor by Accident and Emergency triage nursing staff continue to include infants up to the age of six months and children up to the age of five years with pyrexia.

If Operational Circular 1485/01⁵, 'Guidelines for Triage of Outpatients in Non-Teaching Hospitals', is altered, the guidelines contain a similar attached list, which, like the existing list, is very clear and easy to understand.

WA Health action:

- Operational Directives '*Guidelines for Triage of Outpatients in Non-Teaching Hospitals*' (1485/01) and '*Guidelines for Nurses Performing Triage in Emergency at Non-tertiary Hospitals*' (1019/98) have been reviewed and updated to highlight specific conditions that warrant review by a medical officer and triage guidelines.
- Development of a paediatric observation and response chart is currently being implemented through the Recognising and Responding to Clinical Deterioration project.

Reference: [COLLINS Inquest](#)⁶

⁵ http://www.health.wa.gov.au/CircularsNew/circular.cfm?Circ_ID=7500

⁶ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Collins_finding.pdf

Death in the police cells

Key messages:

- Handover: the importance of determining the collateral history in intoxicated patients.
- Documentation: details pertaining to a patient's care need to be accurately recorded and visible to all staff involved.
- Communication: written and verbal medical advice on head injuries must be provided to patients and their carers even if they discharge themselves against medical advice.

The deceased was a 24 year old male victim of an assault, during which he was punched and kicked about his body and head. The incident occurred at 8:00pm and when police attended the scene they found him lying unresponsive on the ground.

He was taken to the Emergency Department of the local regional hospital for assessment. On examination he was alert and orientated with a normal Glasgow Coma Score but was intoxicated and had slurred speech. A decision was made to keep him in the Emergency Department for a period of observation.

At 10:00pm the deceased requested to discharge himself. At that stage, hospital staff believed, based on the patient's history, that his injuries had been sustained at the earlier time of 6:00pm. As there was no evidence of clinical deterioration over these supposed four hours he was allowed to discharge himself against medical advice.

After leaving hospital he was arrested by police on a charge of disorderly conduct and was taken to the police cells at 10:40pm.

He was subsequently found unresponsive in the cell at 4:45am and was transported back to the local Emergency Department where a CT scan demonstrated a large intracranial haemorrhage. He was transferred to a metropolitan hospital where he died.

As the deceased was in the custody of the police at the time that his condition deteriorated, he was considered a 'person held in care' for the purposes of the *Coroners Act 1996* and it was necessary for an inquest to be held into the circumstances surrounding his death and for the Coroner holding that inquest to comment on the quality of the supervision, treatment and care of the deceased whilst in custody.

The inquest identified that:

Death occurred as a result of left intracranial haemorrhage.

The Coroner commented that:

- 'It is most unfortunate that the deceased was an innocent man who died in police custody'.
- Whilst the supervision, treatment and care of the deceased were sub-optimal; medical evidence at the inquest revealed that the deceased would have been very unlikely to have survived his injuries even if their gravity had been detected earlier.

The Coroner recommended that:

In cases where police arrange for an injured victim of crime of violence or an injured person in custody to be taken to a hospital, police and nursing staff ensure that a reliable history is taken prior to departure of police, particularly if the injured person is under the influence of alcohol.

The custody handover summary requires entry of a summary of any medical treatment or medical assessment made in respect of any prisoner who has been seen by a medical practitioner shortly before being taken into custody or while in custody.

WA Health action:

- WA public hospitals have undertaken the following actions in response to the findings of this inquest:
 - Review of triage and emergency assessment policies and guidelines
 - The WA Health Clinical Handover Policy has been implemented. All WA Health services are moving towards implementing a standardised structure for handover.

Reference: [NJANA Inquest⁷](#)

⁷ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Njana_finding.pdf

Death of a shift worker

Key messages:

- Many shift workers have difficulty sleeping around varying shifts.
- Sleep debt accumulates and can take two normal sleeps to recover.
- The consequence of driving whilst fatigued can be fatal.
- Both organisations and individuals need to minimise this risk.

A 20 year old health care worker died as the result of a single motor vehicle accident whilst driving home from work after night shift. She had been working ten hour night shifts, and frequently had difficulty sleeping during the day. In the days prior to the crash she had taken sedating antihistamines to help her sleep between shifts. She had worked her third night in a row, but had been so tired that her colleague suggested she sleep for most of the shift. Despite this, she was still fatigued at the end of her shift.

The country hospital where she worked made nursing quarters available for staff to sleep when necessary; however on the day of her death the deceased left work and set off to drive to the farm where she was living. Her car left the road shortly after the transition from sealed road to gravel, and struck a nearby tree, causing fatal injuries.

The Coroner concluded that:

Death occurred by way of accident, and that fatigue was a major contributor to the accident.

The Coroner recommended that:

The Coroner addressed road conditions and driver fatigue, by recommending that the following actions be taken:

- Put in place appropriate policies to address the safety of staff who work shift work.
- Monitor fatigue related crashes involving staff working shift work.
- Put in place training and education to address fatigue related issues.
- Review accommodation throughout the state for staff working shifts with a view to ensuring, where possible, accommodation is available for staff who need to sleep prior to driving home.

WA Health action:

- A WA Health Fatigue Management Policy is currently being developed which will provide guidelines for fatigue management as well as information about risks associated with fatigue (local policies have already been implemented in some health services).

Reference: [SWEENY Inquest](#)⁸

⁸ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Sweeny_finding.pdf

Death during restraint

Key messages:

- Restraint should provide the least possible risk to patients and staff.
- Restraint holds should be appropriate to the circumstances of the case.
- The safest option may be for staff to evacuate the area and await further assistance.
- Sedation and obesity increase the risk of restraint.

The deceased was an obese (109 kg) 27 year old male, who suffered from chronic paranoid schizophrenia, complicated by treatment resistance, non-compliance with medication and use of illicit substances and alcohol.

He had a history of aggression and had previously assaulted other patients and staff, and injured staff during a restraint.

On the evening of his death he was an inpatient in a psychiatric hospital. He was noted by nursing staff to be highly agitated and had allegedly assaulted another patient. An empty bottle of whiskey was subsequently found in his room. He was given haloperidol 10 mg (oral) and lorazepam 2 mg (oral) as per his "PRN Medication Chart for Agitation and Arousal".

Once transferred to the secure ward he became non-compliant and dropped to the floor. He was lying prone with one person holding his head, one member of staff to each arm, and two people holding his legs. He was given 10 mg of intramuscular haloperidol. Shortly afterward he vomited and was rolled on to his back. At that stage a "Code Blue" emergency was called. Resuscitation commenced but was unsuccessful.

The inquest identified that:

- A clinical pharmacologist gave evidence that the drugs did not make any material contribution to the death.
- Staff involved in the restraint had all undergone the Aggressive Incident Management Strategies (AIMS) program.
- The Coroner noted that the death was an unexpected result and was unintended on the part of those involved in restraining the deceased.
- While issues were raised at the inquest with respect to whether the restraint process and methods used were optimal, the Coroner noted as a result of his serious mental illness the deceased was behaving in a manner which required some form of restraint.

The Coroner concluded that:

Death occurred by way of misadventure.

The Coroner recommended:

1. That there be a review of the approach taken by the hospital to the searching of seriously ill patients, particularly involuntary patients, and consideration be given to there being regular searches conducted of their property with a view to identifying any alcohol or drugs retained by the patients or any items which could be used as a weapon and place other patients and staff at risk of harm.
2. That the hospital administration review arrangements in place at the hospital with a view to restricting the access of involuntary patients housed in open wards to alcohol and illicit drugs.
3. That WA Health conduct a review of appropriate restraint procedures, focusing on the extent to which the head is held during restraint and particularly during escort with a view to minimising the possibility of injury to patients and staff.
4. That WA Health review training provided to staff in respect to commencing manual restraint of patients with a view to minimising the likelihood that those initial restraint actions will provoke a violent response, particularly where the patient is not threatening immediate violence at the time when restraint is first applied.
5. That WA Health review the nature and extent of training being provided to staff in respect to restraining aggressive and potentially violent patients, particularly in the following respects –
 - There needs to be in place a comprehensive and clear manual which describes in an unambiguous manner a number of alternative restraint procedures which can be used. That manual should be available to persons undergoing the training as a resource and reference.
 - There should be a comprehensive review of the restraint holds being taught with a view to ensuring that the restraint holds are appropriate to different circumstances and provide the least possible risk to patients and staff. While it needs to be recognised that all restraint procedures involve potential risk of injury, those risks should be kept to a minimum.
 - Consideration should be given to whether the extent of training is adequate and in particular consideration should be given to increasing the initial training course from two days to three days and ensuring that refresher courses are undertaken at no more than twelve month intervals and adequately cover de-escalation techniques as well as restraint holds. In the event of any significant changes in training being adopted or after every three years (or such other period considered more appropriate) persons trained should be again given the full training course.
 - The training should include a focus on when smaller or more frail staff members should be involved in a restraint and when it would be unsafe to embark on a restraint at all. There should be a focus on when evacuation is the safest option and when it is best to wait for more staff to become available to assist with a restraint or to call for police or other outside assistance.

WA Health action:

WA Health has undertaken the following actions in response to the findings of this inquest:

- Review and update of policies and guidelines relating to patients' use of illicit substances and alcohol, which includes the searching of patients, identification of hazards and guidelines for management of patients found to be in possession of or under the influence of illicit drugs or alcohol
- A statewide working party is currently considering practices relating to seclusion and restraint.

Reference: [ASHDOWN Inquest](#)⁹

⁹ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Ashdown_findings.pdf

Suicide of a prisoner

Key messages:

- Substance abuse and mental illness are issues commonly seen amongst the prison population.
- Non-attendance to mental health services should be reviewed and followed up appropriately.
- Clinicians should make every effort to ensure patient care meets patient needs.

The deceased was a 38 year old male, incarcerated at the time of his death. He died three days prior to his intended release.

The deceased had a known history of polysubstance abuse and paranoid schizophrenia with fixed delusions. He also had a history of self-harm during his periods of incarceration.

Three months prior to his death he was admitted as an involuntary patient to the State Forensic Mental Health Centre. He was discharged back to prison but compliance with treatment was sporadic. He was non-compliant with his medication in the 12 days leading up to his death.

On the night of his death, the deceased obtained a razor blade and used it to cause deep penetrating wounds to his arms. During a routine cell check the Custodial Officer discovered blood around the deceased and raised the alarm. Resuscitation attempts were unsuccessful.

The inquest identified that:

The Coroner was satisfied that the Prison Health Service did as much as they could to provide the deceased with medical mental health treatment in the context of the *Mental Health Act 1996* and its current interpretation by psychiatric services.

The possibility of implementing Community Treatment Orders (CTO) in prison was explored at the inquest, and the following points were made in relation to this:

- There seems to be ethical concerns within the psychiatric fraternity about the administration of treatment to incarcerated persons on an involuntary basis. Imposing involuntary status on incarcerated persons without access to independent review raises concerns within the profession that use of CTOs in prison environments may be abused.
- Inadequacy of statewide facilities for forensic patients has meant that prisoners are released back to prison environment prematurely.
- Current trends generally appear to confirm that many patients are released (from prison) back into the community without adequate safeguards. It is a known high risk time with respect to the potential suicide for many patients. The option of a custodial CTO would seem to be a good use of time in custody to attempt long term stabilisation by way of medication for those patients for whom medication is effective.

The Coroner concluded that:

Death occurred as a result of exsanguination due to penetration of arm veins. The Coroner found that death arose by way of suicide.

The Coroner recommended that:

1. A dedicated, appropriately resourced, facility for the treatment of prisoner/patients with mental health issues.
2. Meanwhile, there be provision of CTOs in nominated prison/s in circumstances where forensic psychiatrists will be prepared to monitor treatment in the best interest of the patient/prisoner.
3. The continued provision of programs such as Gate Keeper/Lifeline to appropriate prisoners, as well as the continuation of training in those areas for prison officers/ custodial officers.
4. Prisoner/patient medical files be updated when there is a failure to attend a nominated medical review to outline reason given, if any, and action taken to provide follow up.

WA Health action:

- WA Health has reviewed the second recommendation and sought specialist advice. WA Health understands there are serious ethical considerations with the implementation of community treatment orders with incarcerated patients. For these reasons WA Health has not endorsed the recommendation.

Reference: [BRENNAN Inquest](#)¹⁰

¹⁰ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Brennan_finding.pdf

Hanging at home

Key message:

- Serious concerns over suicide risk commands action.

The deceased was a 25 year old man with a history of illicit drug use and mental health issues. On the day prior to his death, he had unsuccessfully tried to commit suicide by attempting to asphyxiate himself using a plastic bag and by strangulating himself using a belt.

On the day of his death the deceased was seen at a mental health unit where he described several suicide attempts, as well as a number of features of psychotic illness including paranoia and thought insertion. Before a formal psychiatric assessment could be arranged, the deceased left the facility and returned to his home in the company of his father. The mental health service requested community follow-up by way of police welfare check and Community Emergency Response Team (CERT) review.

The police visited the deceased at home; noted him to be calm and polite and not displaying any signs of anxiety or paranoia. The deceased declined several offers of transport back to the mental health facility and told the officers that he was going there the following morning to receive further treatment. Due to issues in communication, the CERT team did not attend the patient.

Several hours later the deceased's father returned to the residence to find him hanging from an electrical cord secured to a ceiling beam. The cord was cut down and resuscitation was commenced, however he was pronounced dead on arrival at hospital.

The inquest identified that:

It was noted that the CERT service was well resourced to respond to the deceased's case at the time. CERT officers did not attend the deceased's residence despite information indicating a high risk case (amphetamine use, recent history of suicide attempts, paranoid thoughts and behaviour, lack of sleep).

The Coroner indicated that there was considerable contention between the police and CERT officers about the level of risk to the deceased, and what follow-up care was agreed to and/or necessary.

It was the Coroner's opinion that the CERT response was sub optimal and did not adequately address the mental health crisis of the deceased.

The Coroner concluded that:

Death arose by way of suicide and occurred as a result of ligature compression of the neck.

The Coroner recommended that:

1. I recommend that the Department of Health should, as a matter of priority, consider offering appropriately qualified nurses, undertaking triage duties in mental health facilities, the opportunity to become authorised mental health practitioners under the *Mental Health Act 1996*, so that they can place those who present at triage “on forms” if the need arises.
2. I recommend that the [mental health unit] be provided with sufficient security staff so that staff security is enhanced and those “on forms” can be prevented from leaving the hospital.
3. I recommend that the Department of Health and the WA Police Service work together in order to create an environment that will enable those suffering a mental health crisis receive speedy and efficient welfare checks. The parties should consider co-locating a Department of Health official at the Police Communications Headquarters to assist in determining the priority of cases coming from mental health facilities or services.
4. I recommend that the Department of Health should, as a matter of priority, communicate to its employees engaged in triage and in CERT teams that a welfare check undertaken by the WA Police Service does not replace a thorough mental state examination conducted by senior mental health professionals.
5. I recommend that the Department of Health should, as a matter of priority, create and communicate to its staff working in triage and in CERT teams a clear policy which defines who has ownership of Response Level 1 matters and how and when that party should act to ensure that a request of the Police to locate the consumer is made in a timely manner and in such a way as to ensure a priority response; in the event the police cannot undertake a welfare check in a timely manner, the policy should mandate the appropriate response CERT members should follow.
6. I recommend that CERT officer, rather than the police, should, in all circumstances assess a consumer, who has been placed at Response Levels 1, 2 and 3, unless by doing so CERT staff place themselves at risk by attending to a consumer who is armed, threatening or poses a threat to others. In those situations of danger CERT staff should not attempt to assess the consumer in the absence of police.

Reference: [ELLERY Inquest](#)¹¹

¹¹ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Ellery_Finding.pdf

Thrombocytopenia and intracranial haemorrhage

Key messages:

- Miscommunication relating to education about the patient's condition.
- Misunderstanding about patient residence and the availability of blood products in regional areas.

The deceased was a 63 year old female with known polymphocytic leukaemia which had been diagnosed two years before her death. She had been receiving chemotherapy as treatment for this under the care of a haematologist at a metropolitan tertiary hospital. Interim monitoring was also provided by her GP in the regional centre in which she lived. It was known that the deceased had thrombocytopaenia secondary to her disease, and she required intermittent platelet transfusions, given at the metropolitan hospital, for this.

After receiving one of these transfusions, the deceased was assessed and discharged by medical staff who believed her to be residing locally. She then returned home. Two days later she presented to the Emergency Department of her local regional hospital with a fever. She was admitted with a diagnosis of neutropaenic sepsis and her blood counts also showed severe thrombocytopaenia.

The following morning, arrangements were made to transfer the deceased to the tertiary hospital for ongoing treatment. In the interim, a blood transfusion and a platelet transfusion were prescribed. The blood transfusion was commenced, however the regional hospital did not stock platelets and these had to be obtained from the metropolitan branch of the Australia Red Cross Blood Service. As the request was not marked as urgent, the platelets did not arrive in the regional hospital until the following morning.

Early on the second morning of her admission, prior to retrieval, the deceased developed a severe headache and spontaneous epistaxis. This was controlled and the platelet transfusion was commenced a few hours later. The deceased subsequently developed a further severe headache, decreased level of consciousness and right sided weakness. A CT scan revealed major intracranial haemorrhage and after discussion with her family, a decision was made to palliate.

The inquest identified that:

A post mortem was not performed as the death was not considered to be reportable due to the deceased's death being as a result of a known complication of a patient in these circumstances. The Coroner did not dispute the cause of death noted on the death certificate.

The case was investigated to determine whether or not there were aspects which warranted an inquest. The main issues identified were:

- i. The fact of the deceased not being in the metropolitan area at the time she required an urgent platelet transfusion; and,
- ii. The prolonged delay before platelet transfusion.

The Coroner noted that during the course of the evidence it became apparent there were two miscommunications which, when taken together, contributed to the perception of a catastrophic outcome for the deceased. These miscommunications were related to patient education and obtainability of blood products out of the metropolitan area.

- It is clear there was some confusion among the deceased and her family around the deceased's diagnosis and prognosis (that being prolymphocytic leukaemia).
- There was misunderstanding between the treating clinician at [the tertiary hospital] and the deceased about the deceased's residence being outside the metropolitan area (the protocol being that the deceased stay within the metropolitan area in case follow up treatment was required promptly).
- There were misconceptions around the ordering and delivery arrangements for receiving urgent blood products between the Australian Red Cross Blood Service (ARCBS) and regional areas.

The Coroner concluded that:

Death arose by way of natural causes.

The Coroner recommended that:

1. The Febrile Neutropenia Cards used by most emergency departments for their own chemotherapy patients provide a current diagnosis to enable unexpectedly treating practitioners more ready access to the history and prognosis of the individual patient.
2. (a) I recommend the introduction of "Medical Smart Cards". I understand the ethical considerations which have been raised but note a significant number of deaths would be avoided if doctors needing to treat patients unexpectedly, did not have to rely solely on a patient's memory or understanding of their diagnosis and prognosis, for input.
Failing the introduction of "*Medical Smart Cards*"
(b) I recommend the introduction of hard copy patient diaries for cancer/chemotherapy patients such as those now used by [the regional hospital]. In conjunction with a Febrile Neutropenia Card this would ensure patients fully understood their diagnosis and treatment regime and would be informative for unexpectedly treating medical practitioners.
3. I recommend [the metropolitan hospital] Haematology Day Clinics require progress notes be completed by medical practitioners immediately following a review to ensure staff completing the review are aware of the patient's current status.
4. I recommend patients provided with Febrile Neutropenia Cards are specifically advised in writing it is preferable they remain accessible to their treating clinic at times of vulnerability in treatment.
5. I recommend that Regional Hospitals establish appropriate protocols and procedures for the treatment of cancer/chemotherapy patients who may need urgent blood products, taking into account their individual location.

6. I recommend Medical Scientists located in remote areas inform treating doctors for their area of the relevant timelines for the provision of specified blood products to their location when discussing blood pathology and product ordering.
7. I recommend the introduction of a tool for remote areas similar to that now produced by ARCBS for [the regional hospital] for the processing of requests for urgent blood products.

WA Health action:

- WA Health has reviewed current practices in light of the Coroner's recommendations. The practical issues around the implementation of some recommendations are currently under consideration.

Reference: [TROY Inquest](#)¹²

¹² www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Troy_finding.pdf

Young suicides in a rural community

Key message:

- Ongoing need for greater regional resources for mental health particularly for adolescents and children.

An inquest was held to explore the circumstances of the deaths of four young Aboriginal male persons who died by way of suicide in a small, remote Kimberley Community over a period of approximately 12 months and the death of another young Aboriginal male person whose death occurred shortly afterwards and resulted from self-destructive behaviour; solvent sniffing.

It has long been recognised that mental health issues are a risk factor for suicide and self-destructive behaviour and in these cases the mental health issues were of significance.

It was clear that both the rural mental health services and drug services face considerable practical difficulties in attempting to provide a comprehensive service to remote communities.

The Coroner concluded that:

Five young men aged between 13 and 22 years old died. Four of these deaths were found to be suicides; one death was ruled an accident.

The Coroner recommended that:

The Coroner made five recommendations, with one being relevant to WA Health:

1. That the Health Department give consideration to reviewing facilities available for adolescents and children suffering from mental health problems in the Kimberley with a view to provision of facilities for secure admission so that these persons can be treated as involuntary patients in the Kimberley.

WA Health action:

Significant improvements have been effected since the deaths including provision for a Medical Specialist out-reach program, funding for visiting Psychiatrists, funding for mental health workers and the provision of an Acute Psychiatric Unit at Broome Hospital. However, the Coroner noted that this unit is not intended to provide care for adolescents or children.

Reference: [BALGO Inquest](#)¹³

¹³ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Balgo_findings.pdf

Use of non-proven therapies

Key messages:

- *Primum non nocere* / First do no harm
- Medical and nursing practitioners should undertake a critical evaluation of all treatments and care in which they are involved.

In May 2005, the Kathi Preston Memorial Health Centre (KPMHC) began operating a 'clinic' out of the home of a General Practitioner in Perth. The alleged purpose of KPMHC (Perth) was to cure patients of their cancer by administration of an intravenous high pH cancer therapy devised by Dr Helfried Sartori (Sartori).

Sartori graduated as a medical doctor in Austria in 1963. He had his licence to practice revoked in the USA and has been imprisoned in both the USA and Thailand for convictions relating to his medical practice. He unsuccessfully attempted to become registered as a doctor in Australia in 2005.

Sartori lacked clinical skills and was unable to provide proper medical care while the treatment was occurring. A local GP and two nurses were involved with KPMHC (Perth). Sartori provided advice from Thailand to KPMHC (Perth) with respect to the treatment of patients.

The treatment involved intravenous administration of a range of substances including caesium, dimethyl sulfoxide and Laetrile. These substances are all potentially toxic and there is no evidence that this particular treatment has had any benefit at all to any patient. There is considerable evidence that it is dangerous and has a significant risk of accelerating death. It also caused considerable suffering, which was exacerbated by the setting in which it was provided and the instructions given to participants.

Seven people were given the intravenous therapy by KPMHC (Perth). Of these, four became unwell and died before they had completed the treatment, and two more died of their cancer within the ensuing two months; both of whom had interrupted treatment. One patient died of progressive lung disease with complications from his cancer in 2009.

No one treated with this therapy was cured of their cancer.

The Coroner found that:

KPMHC (Perth) accelerated the deaths of four patients. Further, that the patients and their families were seriously misinformed about the risks involved with this treatment.

The Coroner noted that the treatment would not have been possible in Australia without the input of the two Australian-registered nurses and the Australian-registered doctor. The Coroner referred these practitioners to their relevant registering authorities for their determination of the appropriateness of their conduct.

The Coroner also referred the matter to the Director of Public Prosecutions (DPP) in view of her finding that the deaths of four people were hastened because of the administration of the treatment.

The Coroner recommended that:

1. A form of restricted access for caesium chloride and other caesium salts in the same way as has been provided for Laetrile (B17).
2. Any visa application for entry into Australia by Sartori be closely scrutinised by the Department of Immigration and Citizenship (DIAC).
3. The data available from the operation of KPMHC in Perth be comprehensively evaluation by relevant experts to provide education and information to medical health practitioners as to the effects of administration of these substances.

WA Health action:

- WA Health has reviewed the findings and believes that doctors, nurses, allied health practitioners and pharmacists involved in the provision or recommendation of an unproven medicine or therapy should be satisfied that there is sufficient evidence base and/or experience of use to demonstrate its safety and efficacy. It has therefore engaged with regulatory agencies to promote increased awareness among members.

Reference: [LANTANA Inquest](#)¹⁴

¹⁴ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Operation_Lantana_finding.pdf

Lessons from the quality protection environment

All of the deaths that are reported to the Office of the State Coroner are investigated, but not all go on to public inquest. The non-inquested cases may still yield useful information regarding opportunities for quality improvement in health care institutions across the state.

The Medical Adviser to the State Coroner has made a number of case reports available to the Coronial Liaison Unit within the Patient Safety Surveillance Unit for the purpose of education and quality improvement within the limits imposed by the Coronial Ethics Committee.

Deaths that occur within the WA health system that may have been possibly preventable are subject to mortality review processes via the WA Review of Mortality (WARM) policy and investigation in accordance with the Clinical Incident (CIM) Policy (2011)¹⁵, in addition to Coronial reporting requirements.

The CIM Policy was released 1 September 2011 and introduced Severity Assessment Codes (SAC) which determine the appropriate level of analysis, action and escalation of a clinical incident. SAC 1 events included all clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying condition or illness. In Western Australia, SAC 1 also includes the eight nationally endorsed sentinel event categories.

These deaths are investigated by the hospital/health care service involved in the care of the patient with the goal of systematically reviewing the case to develop recommendations for improvement to the health care system in order to avoid similar tragedies in the future.

The following cases demonstrate some examples of lessons learned in the past year from cases, some of which may have been reviewed under qualified privilege.¹⁶ These are composite cases, based on non-inquested cases identified by the Office of the State Coroner and incorporate the emerging themes from investigations occurring under the WA SAC1/Sentinel Event Program.

Identifying features of individual patients or staff have been removed and at the time of publication there has been no coronial inquest into either of these cases.

¹⁵ The Clinical Incident Management Policy is available via:
http://www.safetyandquality.health.wa.gov.au/clinical_incident_man/sac.cfm

¹⁶ Note the Commonwealth Declaration affording qualified privilege to the AIMS process expired June 2011. Hospitals/health services continue to have the option to utilise qualified privilege via the State legislation (i.e. approved Committees established in accordance with the *Health Services (Quality Improvement) Act 1994*).

Duplicate surgery

Key messages:

- Patients, especially elderly patients, trust and will often not question doctors or the health system.
- New information technology systems should address the issue of duplicate entries; pending this, regular manual reviews should be performed to eliminate duplicate entries.
- When medical records are not available at the time of a pre-operative assessment, this must be addressed prior to surgery.

Mr Y, a 70 year old gentleman, had undergone fixation of an elbow fracture three years ago. One of the wires had begun to protrude, so his GP referred him to an orthopaedic outpatient clinic for review. In the clinic he was assessed and booked for non-urgent removal of the wire (Category 3).

After several months, the protruding wire had begun to cause skin tension and was causing Mr Y significant pain and distress. He was seen again in the clinic and his surgery was booked more urgently as a Category 1 case. He was assessed at the anaesthetic clinic and two weeks after this second clinic review, had the wire removed uneventfully.

Six months later Mr Y received another appointment and allocated date for surgery. Assuming that follow-up surgery was required, he again attended the anaesthetic clinic, but this time his previous medical notes were unavailable. It was not until a skin incision was made in surgery that it was realised that the wire had already been removed. Tragically Mr Y developed a post operative pneumonia and due to his chronic lung disease, died.

Open disclosure and a root cause analysis were conducted into this case. It was found that the patient administration system used to book theatre cases did not automatically flag duplicate bookings when entered and that manual checking by clerical staff was required when entering bookings onto the system.

It was also found that patient's medical notes were often unavailable in pre-assessment clinics.

See also: [WALDEN Inquest](#)¹⁷

¹⁷ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Walden_finding.pdf

Medication error

Key messages:

- Regular review of all medications where separate drug cards exist for anti-coagulants. It must be easily apparent when therapeutic treatment is prescribed.
- The importance of neurological assessment post head injury.
- Good medical practice after an adverse event includes full and frank disclosure with patient and family.
- Investigation into incidents can elicit timely changes in practice and policies.

Mrs Z, a 65 year old woman, was admitted with chest pain. She had a productive cough and fever with right sided chest pain on coughing. Her chest X-ray showed opacification of the inferior lobe of the right lung, and she had a mildly elevated D-dimer. The overnight admitting medical registrar had diagnosed chest infection and possible pulmonary embolism (PE).

Upon consultant review the following morning, it was decided that Mrs Z had no PE risk factors and her signs and symptoms were in keeping with pneumonia. She was admitted to allow the administration of intravenous antibiotics.

Three days later she was recovering well and had an occasional mild headache relieved by paracetamol.

On the morning of discharge she overbalanced whilst putting on her slippers and fell hitting her head. She did not lose consciousness. On assessment by nursing staff and the team intern, she was alert and orientated with no obvious injury.

Three hours later she was discovered obtunded with a Glasgow Coma Score of 7/15. An urgent CT scan of the head showed large acute on chronic subdural haemorrhages. Mrs Z was referred to neurosurgery, but due to the extensive haemorrhage and poor outcome, was palliated and passed away.

During the MET call a review of her medication charts revealed that she was on therapeutic, not prophylactic, clexane which had been commenced on admission for suspected PE.

This case was referred to the Coroner, a root cause analysis was undertaken and findings were discussed via open disclosure with the family.

The Consultant was open and detailed with the family and in reports to the Coroner. She acknowledged where things went wrong and explained steps taken to address this to prevent a reoccurrence. It was decided that a public inquest need not be held.

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