Summary of coronial findings

Name of case	Main points of the case	Coroners recommendations
Inquest into the Death of Troy Almond Septicaemia due to Streptococcal (Beta Haemolytic Group A) infection	Online Media: https://www.9news.com.au/national/troy-almond-inquest-coroner-finds-doctor-resbonsible-for-death/c72c25b0-c056-4c48-8c8b-b6b0c6bab620 • Paediatric Case • Troy died due to a failure by the treating specialist in the Emergency Department of the Shoalhaven District Memorial Hospital on 21 March 2016 to recognise signs of toxicity caused by possible sepsis, to investigate the possibility of sepsis, and administer antibiotics. Septicaemia due to Streptococcal (Beta Haemolytic Group A) infection • Coroner recommended use of Paediatric Sepsis Pathway Standard Paediatric Observation Chart ("SPOC") • Use of Between the Flags (BTF)	• Counsel for the Almond family invited me to make a recommendation that "the SDMH consider implementing an orientation program for all new staff commencing work within the Emergency Department that identifies all between the flags and sepsis guidelines that are utilised within the Emergency Department and which involves a demonstration of the documents and/or computer software used within the ED to implement those guidelines".

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Inquest into the death of Roy Jacobs Coronary artery disease	• Online Media: Nil Found • Missed opportunity to escalate based on obs. • Roy Rodney Jacobs was a 48 year old Aboriginal man who died unexpectedly at the Cherbourg Hospital in the early hours of 31 August 2017. • Roy had travelled from Brisbane to Cherbourg on Friday 26 August 2016 to attend a funeral. He consumed alcohol at a gathering and had a fall while intoxicated. • Roy presented to the Cherbourg Hospital on three occasions after that fall – 28, 29 and 30 August – and was admitted to hospital on the final presentation for treatment of pneumonia. He was found unresponsive, not breathing and pulseless at 5:08am on 31 August. Unfortunately, despite emergency resuscitation efforts, Roy was unable to be revived. • This is the third patient death at a DDHHS hospital since 2013 where clinician understanding of and compliance with the Q-ADDS tools has been an issue examined at inquest. • the Q-ADDS tool was used by the night shift nurses at Cherbourg Hospital to record Roy's observations but they did not use it to escalate what those observations indicated about his condition. The locum medical officers both seemed to consider the Q-ADDS to be a nursing tool and had not considered how it should inform their clinical practice. • The critical issue appears to be a lack of understanding by medical and nursing personnel alike that Q-ADDS scores mandate the corresponding actions required unless the patient's parameters have been modified and appropriately documented by a senior medical officer.	• Failure to recognise and respond to clinical deterioration and non-compliance with early warning and response tools is a recognised issue across the health sector, public and private. I take this opportunity to reiterate the importance of all hospital providers taking steps to embed early deterioration detection and clinical escalation in daily clinical practice and clinical culture through effective training, compliance monitoring and proactive feedback to staff whenever non-compliance is identified.

Name of case	Main points of the case	Coroners recommendations
Inquest into the death of Mr B Subdural haematoma	• Online media: Nil found • Missed neurological signs • multiple presentations to rural hospital emergency department with ongoing headache, • clinical assumption of acute alcohol withdrawal syndrome, • failure to recognise and respond to clinical deterioration, use of early warning and response observation tools (Q-ADDS), • undiagnosed subdural haemorrhage • Mr B's pain score was 9/10 when he presented on 28 March 2015 but this was not reflected in the triage score (4) or on medical review – the RCA team questioned that if the clinical picture did not reflect the pain score, why this was not documented? It was felt that that triage score may not have reflected the potential seriousness of the headache symptoms and medical review may have been indicated at this time. The re-presentation with headache and diagnosis of cluster headache may have given clinicians a cognitive bias and clouded their clinical judgement. • There was no ongoing monitoring of the pain score which made it unclear whether the headache was improved, unchanged or worse • There were no specific neurologic observations apart from those in the Alcohol Withdrawal Scale record.	• Failure to recognise the significance of Mr B's ongoing headache – clinical education around headache as a potentially significant symptom and the use of aspirin in headache treatment (not to be used until haemorrhagic cause is excluded) and triage training for nurses; • Failure to recognise clinical deterioration – nursing staff to undertake an awareness program for recognising clinical deterioration; • Documentation – measures to improve documentation to record Findings of the investigation into the death of Mr B, a 41 year old indigenous man Page 6 negatives in history taking and the formulation of differential diagnoses; • Poor clinical record management – review of record management processes to avoid clinical records not being available at point of care; and • Cultural practice – completion of the Cultural Practice Program (mandatory training) for all staff.

Name of case	Main points of the case	Coroners recommendations
Inquest into the death of Theodoras Simos Unknown with pre-existing cardiac disease	• Online media: Nil found • Mental Health case • Complicated case while an involuntary patient – absconded from a regional hospital, detained by Police and brought to rural hospital • Mr Theodoras Simos was 48 years of age when he died on 8 July 2010 at the Riverland General Hospital in Berri (the RGH). • Mr Simos had a long history of mental illness as well as a multitude of physical illnesses. He was diagnosed with schizoaffective disorder in 1985. • He had a number of hospital admissions in respect of his psychiatric disturbance and he had absconded on a number of occasions while hospitalised. • He underwent a number of periods of detention under the Mental Health Act 1993. From time to time the deceased required sedation to manage acute psychotic episodes. • It was noted that Mr Simos had experienced adverse reactions to sedation, particularly in relation to its affect on his breathing. • Mr Simos' physical illnesses included poorly controlled diabetes, high cholesterol, chronic sleep apnoea, chronic obstructive airways disease and morbid obesity. He weighed 120 kilograms. • Mr Simos left the confines of the Lyell McEwin Hospital while he was subject to a level 3 treatment order that had been lawfully imposed. In doing so he left without leave and became a patient at large as defined within the Mental Health Act 2009. • He was therefore liable to be taken into the care and control of the police; 2) SAPOL lawfully took Mr Simos into their care and control and lawfully delivered him to the hospital;	• 'There should be ongoing awareness by Rural and Remote Consultants of the need to assess carefully risk/safety factors and the limitations of rural hospitals in managing acutely psychotic and violent patients in rural SA; Reinforcement to transport and retrieval services to carefully risk manage/assess acutely psychotic patients in rural hospitals with a view to early transport where possible (I should also say that I am well aware that these recommendations form part of current policies of these organisations but that does not prevent me from stating them here).' • That in according priority to the transportation of mentally ill patients, that priority be given, wherever possible, to the transport of patients who are the subject of inpatient treatment orders under the Mental Health Act 2009 or who are the subject of other measures that have been invoked under that Act. •

	• Mr Simos was lawfully kept at the hospital. Similarly, the treatment that he received, which some might characterise as involuntary treatment, was authorised by the Mental Health Act 2009. It was lawful treatment; • Appropriate efforts were made to arrange transport of Mr Simos back to his treatment centre, namely the Lyell McEwin Hospital. The efforts to have him transported were unsuccessful insofar as they were delayed because of the exigencies of workloads of the RFDS and MedSTAR. It would have been inappropriate for Mr Simos to have been transported by road in an ambulance; • Mr Simos' treatment at the hospital was appropriate; • The precise cause of Mr Simos' death cannot be ascertained. • In his second report Dr Joyner has stated that he considers that this case is typical of the challenges presented to many small rural hospitals struggling to manage an acutely psychotic patient. He feels that this case illustrates the typical complexities associated with the management of those patients. In his opinion the answer to improving outcomes in these cases rests with coordinating a state-wide integrated management service to provide a structured team involving the local hospital staff, doctors and nurses, Rural and Remote Mental Health, MedSTAR and rural doctor groups. • There needs to be a defined 'team leader' who accepts the responsibility for final management decisions and leads the team through the process. He opines that there should be a reasonably defined 'flow chart' that all teams follow, linked with areas of critical assessment and management steps outlined, including drug use, restraint use, transport type and destination. In his first report • Dr Joyner also referred to the need for transfer and retrieval services to carefully risk manage and risk assess acutely psychotic patients in rural hospitals with a view to early transport where possible. I take it from	

	this that Dr Joyner would be of the view that priority ought to be accorded to the transfer of acutely psychotic patients in certain circumstances. One would add to this that where a patient is the subject of an order under the Mental Health Act, the need for transfer of the acutely psychotic detained patient would be all the more acute.	

Name of case	Main points of the case	Coroners recommendations
Inquest into the death of Naomi Williams Septicaemia	Online media: SBS IDEAS https://youtu.be/9VsU1tgENkA [20min] • Obstetric case • Initial vital signs taken bordered on the first category of alert of the track and trigger chart – not acted upon. Given pain relief and sent home – 34 minutes later. Died 15 hours later. • Should have used the standard maternity observation chart. • Naomi should have been identified as a high risk patient both for triage and for assessment and was not. • Naomi died from septicaemia, secondary to Neisseria meningitides infection • At about 14:30 hours on 1 January 2016, Naomi arrived at Tumut Hospital by ambulance in extremis. • She had been briefly treated in the Emergency Department of Tumut Hospital in the early hours of 1 January 2016 ('the presentation'). • Naomi's history of numerous and frequent presentations to the Emergency Department in the months immediately preceding that presentation, where she received brief symptomatic treatment rather than necessary investigation or specialist intervention of underlying causes, likely led to her having reduced expectations of care at this time. • It could not have been known by the nurse and the midwife at the presentation that Naomi was suffering from a bacterial infection, which was life threatening. • It was not known that she had high complex needs because her hospital notes were not read at the presentation. It was not known that she had been assessed with a high risk pregnancy, about two weeks earlier, because that information had not been flagged. • On the basis of some of the clinical information known and recorded at the presentation Naomi should have been further investigated. She was discharged earlier than was clinically indicated, after which she deteriorated from septicaemia associated with Neisseria meningitides infection.	• That consideration is given to providing a training session to all staff about the importance of safety alerts (such as "re-presentation calls for medical review", or "high risk pregnancy") and a consistent method for implementing such alerts is communicated to all staff. • That consideration is given to implementing a Nurse Directed Emergency Care (NDEC) policy as a matter of urgency. • That consideration is given to strengthening the Aboriginal Health Liaison Worker program • That consideration is given to auditing the possibility of implicit bias by recording statistics for Indigenous and non-Indigenous patient triage categories, discharge against medical advice, triage times and referrals for drug and alcohol reviews for patients presenting to the Emergency Department at Tumut Hospital. • That consideration is given to identifying other assessment tools to measure the existence of implicit bias in the provision of health care and commit to making such tools available to Tumut Hospital.

Name of case	Main points of the case	Coroners recommendations
Inquest into the death of William Gripton Multi organ failure due to atypical pneumonia	• Online media: Nil Found • Mr William Gripton was 62 years of age when he died on 13 May 2008. His cause of death was multi organ failure due to atypical pneumonia • Initially GP missed seriousness of condition • Admitted to rural hospital • Nurses increasingly concerned • GP not as concerned • Poor communication from GP to hospital nursing staff regarding fluid challenge given for persistent hypotension • Urgency of deterioration not handed over at change of shift • Afternoon shift noted hypoxia – previously recorded as 74% and 76% and not acted upon • Urgent transfer organised after this point • Intubated and ventilated at rural hospital • Transferred to metro hospital via RFDS • On arrival at the Royal Adelaide Hospital he was found to be in overwhelming sepsis, he had renal failure, hepatic failure and was suffering refractory shock and had high oxygen requirements. He was immediately placed on dialysis and received aggressive support, but that morning became hypertensive and bradycardic. CPR was commenced but Mr Gripton could not be saved and died at 0941 hours in the Royal Adelaide Hospital.	• I recommend that the Department of Health support the continuation of the work of the Deteriorating Patients Steering Group with a view to the implementation of systems for the detection and subsequent management of deteriorating patients[1].

Name of case	Main points of the case	Coroners recommendations
Inquest into the death of Carmel Killackey Pulmonary thromboembolism	• Online Media: Nil Found • Visitor from metro to rural location. Becomes unwell while on holiday • Attended UCC describing shortness of breath, and chest pain. 3 other patients in UCC at the time including one with acute chest pain. • One RN and one graduate nurse • Symptoms 'settled' after treatment (given pink mix (antacid + local anaesthetic orally), assumed to be gastrointestinal and was discharged from UCC • No ECG done • Drs notes did not record the history of previous Pes • No diagnostic decision making tools for PE were used. • No further investigations after initial observations. At a minimum, ECG, bloods and CXR should be performed. • Dr took too many elements as correct based on Patient say so rather than confirm by checking e.g. INR status. • History included hypertension, Factor V Leiden thrombophilia, and multiple instances of pulmonary embolism • Symptoms continued but she returned home to Ringwood North the next day • Ambulance called shortly after arriving home • Went into cardiac arrest soon after arriving at Box Hill hospital • Cause of death extensive Pulmonary embolism throughout all lobes and DVT •	• Assessment at the UCC was inadequate • The clinician did not positively diagnose a cause for her symptoms and failed to exclude potentially serious diagnosis despite her having major risk factors for PE. • Chest pain algorithms, flow charts and protocols must be followed in UCCs. • Must be a full set of vital signs completed before discharge • All patients presenting with chest pain must have an ECG. • UCC staff be rotated into Regional Eds to update skills

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Mrs H – non inquest findings Acute renal failure	• Online Media: Nil Found • Complication of NSAID use • Referred by community nurse to small rural hospital after 4 day hx of left knee pain, poor mobility and inability to cope. No previous history of injury to the knee or knee pain. • Prescribed several NSAIDs • Sent home • Increasing issues and 'coughing up blood' • Two doctors work opposite each other but there was no handover process or system in place for a handover to take place during the morning ward round other than the previous entry in the patient record. • GI complications picked up, gastroscopy advised, pt refused. Clinical staff confounded by Mrs Hs non compliance • communication and graded assertiveness issues between two medical staff and between some nursing staff and the medical staff also impacted on the recognition and interpretation of clinical signs and symptoms and Mrs H's deterioration; • limited or absent clinical handover between treating medical officers due to fatigue leave; and • a faulty printer used for pathology result printing. • Main deterioration happened over Easter long weekend.	• orientation on how to access pathology results and how to use the electronic systems (The Viewer/AUSCARE/AUSLAB) must be provided to all medical staff (temporary and permanent) + Escalation of Clinical Issues/Supervision on commencement (HHS wide) – this has since become a routine part of the Medical Officer Orientation at the hospital and registered nurses now all have access to these systems as a backup • orientation including how to access pathology result and how to use the electronic systems (The Viewer/AUSCARE/AUSLAB) must be provided to all nursing staff (HSS wide) – this has since become part of the facility orientation by the Director of Nursing/Senior Nurse on shift when a new Medical Officer commences • the Journey Board and handover sheet should be used as a flag until all current pathology results for inpatients have been reviewed [may require reconfiguration of the staff station to ensure that the Journey Board can be easily viewed] (the small rural hospital) – in the absence of sufficient funding to modify the staff station and move the journey board, an alternative strategy has been implemented whereby a standalone lap top is now used for Patient Flow Manager. I am advised that observational auditing of Patient Flow Manager has shown a marked improvement in use and timeliness of completion of tasks. • Clinical staff must ensure that printer which receives pathology results is operational on a shift per shift basis; if the printer is not functioning alternative arrangements must be made to redirect/receive pathology results (the small rural hospital) • Intraosseous devices must always be available for emergency use; emergency supplies must be procedure from the nearest hub until standard orders are received if supplies have been exhausted (HHS wide) – staff orientation and signage implemented to ensure staff awareness

	• Timeliness of pathology collection – bloods taken but not sent by courier until the next day – nursing decision. • Senior medical officer failure to follow up and review blood results • Failure to consider abnormal pathology result • Monitored in Urgent care after a deterioration – period of 'rhythm change' and unresponsiveness of 30 seconds noted in notes but actual rhythm not identified	that emergency supplies can be borrowed from district hospital Emergency Department until orders arrive • All Q-ADDS charts [& CEWT] must be correctly completed including all columns must be scored and actions/escalations recorded as per the HHS procedure Clinical Observations (Recognition and Management of the Deteriorating Patient) and the on-line Recognising and Responding to Clinical Deterioration education (HHS) – compliance is being audited through annual Queensland Bedside Safety Audit • All nursing staff must read and sign for the procedure Escalation of Clinical Issues (the small rural hospital) – completed as at November 2016. • All clinical staff be provided with training in how to assess the hydration/dehydration status of a patient (the small rural hospital) – nursing staff have since received training delivered by a Senior Medical Officer • All nursing staff to receive/repeat graded assertiveness training [on-line or face to face] and to understand when to escalate clinical or workplace issues to Line Manager or above (the small rural hospital) – as at November 2016, staff had completed graded assertive training online and additional Communication and Patient Safety Training was being rolled out to all the HHS facilities

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The following two cases were post introduction of National Standards:	• Online Media: Nil Found • All three died from overwhelming infection and the issue arose in relation to all three deaths was whether they had received timely and appropriate treatment whilst in the care of the rural hospital.	
Graeme Barry Gulliver	• **Graeme Gulliver 21 years old, Leptospirosis infection** ○ Initial care by GP excellent, communication to patient and receiving hospital about seriousness of condition and results of blood tests thorough. ○ Receiving hospital nurse did not write down anything about the call be remembers receiving it ○ Following day Mr Gulliver had deteriorated and attended the hospital. ○ Nurse was given the blood test results that the GP had insisted Mr Gulliver's partner write down and take with them to the hospital. ○ Nurse stated patient looked well and gave a triage category 4. ○ She phoned pathology asking for a copy of results but made no notes of the call. ○ Examined by Dr – dismissed haemoptysis, considered blood test results but did not attribute seriousness of them. Took more bloods. Pt sent home ○ At home, fever worsened, pt in pain, partner wanted to take him back to hospital but patient	The culture in the facility influenced the process for the review of patients who require admission; this led to the patient not being reviewed by a medical officer on admission and a delay in recognising the severity of the illness; this contributed to the failure to provide appropriate and timely treatment and to the patient dying. The correct utilisation of the ADDS tool was not embedded in workplace culture; this led to the ADDS actions required for escalating care not being followed and a delay in recognising the severity of the illness and appropriate treatment of the infection; this contributed to a failure to provide timely care and to the patient dying. The workplace culture was to value historical processes over current best practice for standardised clinical handover; this led to variable handover and unreliable transfer of information, which contributed to a failure to escalate care and to the patient dying. Medical officer fatigue in rural facility when unforeseen understaffing occurs may have led to the patient not being reviewed by a doctor on admission and the subsequent delay in recognising the severity of illness and providing appropriate and timely treatment.

	refused as the Dr had said not to come back until blood test results were available. ○ Haemoptysis worsened. ○ Ambulance called, Paramedic would not listen to partner when patient too breathless to give full story. ○ Taken back to the hospital ○ Triaged category 4. T38.8, HR 116, BP 112/62, RR 36, SpO2 93% on 4L). ○ No track and trigger chart filled out. If it had been – an urgent medical review would have been done ○ Decided to wait 10 min and do another set of obs. At this time, RR 24, SpO2 96% on 6L, HR 113, BP 118/62. The ADDS score at this time, if calculated, would have required medical review. ○ Dr phoned – nurse downplayed seriousness of presentation or history. Nurse said – a little bit of blood in sputum. ○ Retrospectively filled in the ADDS tool and saw that medical review needed but thought the phone call she had made to the Dr fulfilled this criteria. ○ Ongoing haemoptysis overnight as well as vomiting. RN did not see him after 3 but wrote notes at 4 and 5 am based on 3 am observations. ○ Enrolled nurse concerned – asked for RN review ○ Obs at 6am ADDS score required a medical review. Did not happen.	The provision of clinical governance is hampered by the multiple priorities and additional non-clinical duties placed on Nurse Unit Managers managing clinical areas. The report made a number of recommendations in relation to the shortfalls identified: A procedure is developed that instructs medical officers to do an on-site medical assessment on all patients who require admission Develop and deliver a Recognition and Management of Deteriorating Patients one day workshop for nursing and medical staff to develop clinical champions in the workplace This would be implemented if 25% of the staff from each clinical unit attended a workshop The patient's ADDS score is quoted in all clinical handovers between clinical staff The facility undertake bi-monthly audits of the ADDS tool and the recommendations from these audits are reviewed by the Health Service Clinical Care Review Committee for a period of two years. Strengthen the process of bedside clinical handover by implementing the Australian Commission on Safety and Quality in Health Care OSSIE Guide to Clinical Handover improvement.

	○ Change of shift. Pt condition worsened. Next RN actioned ADDS straight away. ○ SB Dr. Antis, IV, CXR and closer observation ○ 200ml Hameoptysis ○ Moved to resus ○ Intubated and ventilated ○ Arranged urgent transfer but pt died of massive pulmonary haemorrhage. ○ After the event, the sputum specimen that had been handed over by the previous RN as blood stained sputum was found by RN who recorded it as 20-30ml of frank blood.	Facility medical representative meet with local General Practitioners to develop a local process for referral of patient s to facility for review and admission. This should include a mandatory doctor to doctor handover. The Commissioning Authority recommend to the Medical Director, QAS, to undertake a root cause analysis or similar clinical analysis in relation to the transportation of Mr Gulliver. A centralised system for backfill of medical officers for rural facilities is developed to assist in managing fatigue. Provide support to Nurse Unit Managers that will allow them to undertake tasks associated with clinical governance to enable them to embed and monitor cultural change with recognition and management of deteriorating patient and specifically with the utilisation of the ADDS tool
Joanne Lee Harrison	• **Joanne Harrison, 28 years old, streptococcal meningitis and septicaemia** ○ Went to GP with symtoms of sore throat, unwell, sore glands in her neck and a bad headache. Febrile 38.9. Hr 105. GP had bloods taken, prescribed broad spectrum AB. Told to go to hospital if worse ○ Pathology rang GP with results, GP rang pt and told her to get to hospital immediately. Told her to say her WCC was 35 ○ GP rang hospital to speak to a doctor but got a pre recorded message to say the hospital was	The culture in the facility influenced the process for the review of patients who require admission; this led to the patient not being reviewed by a medical officer on admission and a delay in recognizing the severity of the illness; this contributed to the failure to provide appropriate and timely treatment to the dying patient. The correct utilization of the ADDS tool was not embedded in workplace culture; this led to the ADDS actions required for escalating care not being followed and a delay in recognising the severity of the illness and appropriate treatment of the infection; this contributed to a failure to provide timely care and to the patient dying.

	closed. There was no capacity to leave a message. Unable to get through at all. ○ Pt presented to hospital, triaged as category 4. T 38.7, HR 115. Sister told nurse of WCC but RN did not make a record of it in the notes. ○ No Dr at the hospital at that time, Dr B on call ○ RN phone Dr – Dr said likely a generalised flu like vial illness, give fluids, continue Abs ○ Next obs T 39.1, HR 94. Neck stiffness, photophobia, Given paracetamol. ○ Handover to night staff. ○ Obs T 37.7, HR 69, RR 18, BP 92/62, SpO2 97% and pain 6/10 ○ Looked unwell. Dr Called, pt admitted – further fluids ordered, Endone for headache. ○ Did not tell GP re photophobia or neck stiffness ○ Dr did not know that GP had referred pt to hospital ○ Mildly breached first level of ADDS all night. ○ Seen on ward round, did not look at ED notes – kept in a separate location from bed notes. ○ Dr spoke to Pt for 15 minutes, decided she did not have neck stiffness or photophobia without doing physical examination ○ Next obs ADDS breach – T 38 degrees – no action taken. ○ Pt anuric despite all IV fluids given. ○ Review by Dr.	The majority of triage training within the facility is self-directed and learnt on the job from other local clinicians; this has led to a culture within the facility to allocate a conservative triage score and to the patient not accurately triaged, this contributed to a failure to provide appropriate and timely care and to the patient dying. The workplace culture was to value historical processes over current best practice for standardized clinical handover; this led to variable handover and unreliable transfer of information, which contributed to a failure to escalate care and to the patient dying. The RCA team also identified the issue of inadequate documentation in the medical records. The recommendations arising out of the findings were: A procedure is developed that directs medical officers to do an on-site medical assessment on all patients who require admission. The Emergency Admission to a Rural Hospital or Multipurpose Health Service Procedure is included as a mandatory component of all rural hospital and MPHS Medical orientation programs. The patient's ADDS score is quoted in all clinical handovers between clinical staff. Bi-monthly audits of the ADDS tool and the recommendations from the audits be reviewed by the Health Service Clinical Care Review Committee for two years.

	○ Found blurred vision, looked unwell, left pupil dilated relative to right, ongoing headache and neck stiffness. Move to Resus for immediate transfer. Started Abs per meningitis guidelines ○ Dr escorted pt – on the say SpO2 dropped, Code 1 transfer as pt bagged – unable to keep saturations up ○ Upon arrival, intubated and ventilated, deteriorated to brain death. She became an organ donor.	ED triage forms be formatted to allow only one set of observations to be recorded and a column added called ADDS score. Develop and deliver a Recognition and Management of Deteriorating Patient one day workshop for nursing and medical staff. All staff working in rural ED departments attend a triage training workshop within 3 months of commencing work in the ED. Strengthen the process of bedside clinical handover by implementing the Australian Commission on Safety and Quality in Health Care OSSIE Guide to Clinical Handover Improvement. Facility medical representative meet with local General Practitioners to develop a local process for referral of patients to facility for review and admission which should include a mandatory doctor to doctor handover. CHHHS Legal Unit provide information session to reinforce required standard of documentation in the patient record to clinical staff in the rural facilities on three occasions by 31 December 2013.

Name of case	Main points of the case	Coroners recommendations
Kevin Edward Fogarty Pneumonia as a result of a melioidosis infection	• Online Media: Nil Found • Atypical presentation of community acquired pneumonia – Melioidosis • Complicated by Alcohol withdrawal • Hypoxic confusion mixed with alcohol withdrawal • Increasingly concerned nurses not allowed to call resistant GP – Dr denied this in the inquest • GP believed the antis he gave the patient were the only treatment options available • Severe deterioration – several calls to GP • GP sedated patient because of agitation • Severely hypoxic • Needed intubation while waiting for transfer by RDFS • Cardiac arrest immediately following intubation • Resuscitation unsuccessful •	- hospital should have guidelines to stipulate when nursing staff are to contact a doctor. - The GPs working in these areas should have clinical support

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Jillian Peta McKenzie Cardiac arrhythmia	• Online Media: Nil Found • Cardiac presentation • Patient chose rural hospital because there was a 7 hour wait at regional hospital • Junior doctor working – Second year doctor having completed his compulsory intern training which is first year doctoring. • Diagnosed muscular pain and given brufen and discharged • Died the next morning • Poor documentation – many 'conversations' not recorded, so inquest all about he said and she said • National Heart Foundation guidelines not followed	- Junior doctors should not be sent to hospitals where they are the sole doctor in charge. - If they are to be sent, there need to be clear lines of communication established. - Adequate preparation to work in an isolated hospital