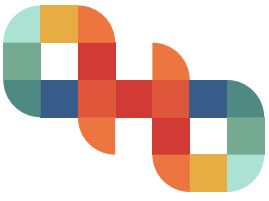
Systemic investigation into the health care provided to Miss Sandy at Doomadgee Rural Hospital



OFFICE OF THE
HEALTH
OMBUDSMAN

Acknowledgement

The Office of the Health Ombudsman acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and emerging.

Aboriginal and Torres Strait Islander peoples are advised that this report contains the name of deceased persons and refers to the death of Aboriginal women, including a 37-year-old from Doomadgee, Queensland.

While our office has made every effort to acknowledge the concerns and actions taken by Miss Sandy and her family in accessing healthcare, as well as taking into consideration the customs and beliefs of the community, the reader may find the content very distressing.

At the family's request, Adele is referred to as Miss Sandy throughout the report.

Contents

1. Introduction

Section 25(c) of the *Health Ombudsman Act 2013* empowers the Health Ombudsman to identify and report on systemic issues in the way health services are provided, including issues affecting the quality of health services.

This investigation reviewed the health care provided to Miss Sandy by Doomadgee Rural Hospital (DRH), with particular focus on November 2019 to her passing on 30 May 2020.

The Office of the Northern Coroner in Queensland advised on 18 February 2022 of its intention to hold an inquest into the death of Miss Sandy, which began in July 2022. The Northern Coroner would also be considering the deaths of a further two women from rheumatic heart disease-related complications within the remote community of Doomadgee, namely Ms Yvette (Betty) Booth and Ms Shakaya George.

It is important to note that this report focusses on identifying deficiencies in the systems and processes in place at the time rather than on the performance of individual practitioners.

1.1 Miss Sandy

Miss Sandy was an Aboriginal woman who resided at Doomadgee, a remote community in northwest Queensland. She was diagnosed with rheumatic heart disease (RHD) as a young child and at 26 years of age underwent a mechanical heart valve replacement, which necessitated ongoing medication and medical review. Consequently, she routinely attended DRH for treatment and medication.

On 27 May 2020, she presented to DRH and was admitted with atrial flutter for cardiac monitoring. She was discharged on 29 May 2020 but re-presented via ambulance on 30 May 2020 with abdominal pain and shortness of breath. She was triaged at 4:15pm and was noted as unresponsive with cardiopulmonary resuscitation (CPR) commencing at 5:15pm. Miss Sandy unfortunately passed away and CPR was ceased at 6:16pm.

Miss Sandy is survived by her husband, four children, her mother and her sisters and brothers. She was very close to her family, and they loved her dearly and needed her. She is greatly missed and mourned by her immediate and extended families and community.

Miss Sandy's husband provided the OHO with the following statement about his late wife:

'My family and I miss Adele everyday ever since we lost her.

Just recently our wedding anniversary went past for the third time without her.

Our wedding anniversary was on the 18th of November. We all went out to the cemetery to say happy wedding anniversary to her, my wife, my kids' mother. We miss her every day, every night.

I went back out to the cemetery myself at 8pm that night and asked why you had to leave me Adele. I cried but that's all I can do right because crying won't bring her back.

I took the family out to one of her favourite fishing places a couple of weekends ago where one of our daughters took a picture of me and my wife under a big tree near the river. We all stood and had little moments. We hugged and the girls cried.

Yes our wedding anniversary and her birthday are the hardest part of our lives.

I miss Adele every day and every night I'm in our bed. I just wish I could wake up one morning and find her sleeping next to me.'

1.2 Rheumatic Heart Disease

RHD is a disease of the heart, involving damage to the valves, caused by acute rheumatic fever (ARF). ARF is an illness caused by an autoimmune response to group A streptococcal bacterial infection, otherwise known as strep A infection. During ARF the heart valves, lining or muscle can become swollen and damaged which affects the heart's ability to function adequately and may require surgery to repair or replace damaged heart valves. Antibiotics are used in RHD to prevent recurrent ARF and subsequent damage to the valves.

ARF and RHD was once common in Australia, and across the world, however rates have decreased during the 20th century, and this is primarily attributed to improved socioeconomic conditions and reduced household crowding, better access to healthcare and the availability of penicillin to treat streptococcal infections. RHD is a preventable disease that can be fatal and is known to disproportionately affect Aboriginal and Torres Strait Islander peoples in Australia.

According to RHD Australia[1], those at particular risk in Australia are:

- Aboriginal and Torres Strait Islander peoples, particularly those living in rural or remote settings across central and northern Australia.
- Aboriginal and Torres Strait Islander peoples living in urban settings, particularly where there is household crowding.
- Māori and Pacific Islander peoples, particularly where there is household crowding.

The Australian guideline for prevention, diagnosis and management of ARF and RHD notes that the *"high recurrence of ARF highlights the need for Australia's primary health care system to strengthen partnerships with people with ARF and their families around disease education, secondary prophylaxis, and management of ongoing risk of ARF."* Importantly, it is also noted that despite advances in medical treatment and management of ARF and RHD, the associated health benefits at population and community level have not been as evident for Aboriginal and Torres Strait Islander peoples as they have been for non-Indigenous Australians. The guidelines note that this trend suggests a growing need for the healthcare system to place greater focus on a socioecological model for the provision of healthcare services which understands the personal and environmental factors that determine health behaviours and acknowledges the unique culture of Aboriginal and Torres Strait Islander peoples.

[1] RHD Australia (ARF/RHD writing group). The 2020 Australian guideline for prevention, diagnosis and management of acute rheumatic fever and rheumatic heart disease (3rd edition). 2020

2. Facility

Doomadgee is a remote town on the Nicholson River in the far north-western corner of Queensland, near the Gulf of Carpentaria. The Waanyi, Gangalidda and Garawa people are recognised as the Traditional Custodians for the area with Aboriginal and Torres Strait Islander people comprising 93.7% of the population of approximately 1400 people.

Doomadgee Hospital is a facility within the North West Hospital and Health Service (NWHHS). DRH is a Level 2 remote hospital under the Rural and Remote Clinical Services Capability Framework.[2] It provides 24-hour acute inpatient and accident and emergency care. The Clinical Services Capability Framework (CSCF) details the workforce requirements for health facilities according to the service capability level and specific service. The emergency services module details that a level 2 facility must have 24-hour access to registered medical practitioners including:

- one with credentials in emergency medical care,
- a registered medical practitioner is to be available on-site within 30 minutes in normal circumstances
- 24-hour access to a registered nurse (RN) with (or working towards) advanced qualifications in rural and remote practice,
- a registered nurse with advanced life support (adult and paediatric) and hospital approved triage competency.
- access to a pharmacist (or approved RN) on weekdays for medication services
- An Aboriginal and Torres Strait Islander health worker must be accessible 24 hours where required
- access to patient support staff and security personnel.

The community of Doomadgee also has a primary care (GP) service called Gidgee Healing (GH), which has been providing primary health care services in Doomadgee since 2018. When GH opened operations in Doomadgee, primary health care services transitioned in stages from Queensland Health to GH as the Aboriginal Community Controlled Health Organisation, with RHD transitioning to GH in 2020. However, due to staffing issues at GH, Queensland Health have continued to provide primary health care services through DRH.

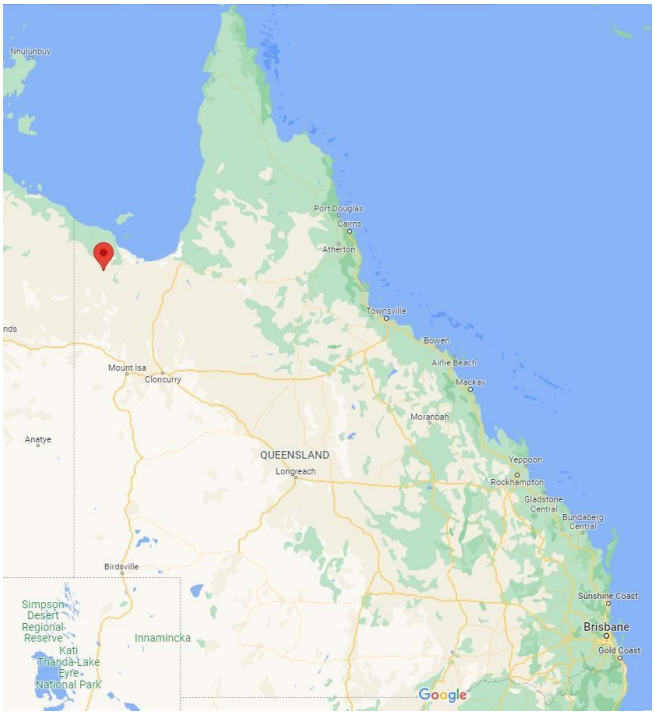
Over recent years, several concerns have been raised by the Doomadgee community about health service provision. The Office of the Health Ombudsman (OHO) is aware of a previous Coroner's inquest into the death of the Little Gungallida Girl at DRH on 23 July 2009 and a community protest in Doomadgee in response to the death of an 18-year-old local woman who died at DRH on 23 September 2019.

The Anti-Discrimination Commission Queensland commissioned a report[3] in 2017 scoring Queensland hospital and health services (HHS) on criteria to identify levels of institutional racism in Queensland's health system. This report identified 'high' or 'very high' levels of institutional racism in the sixteen HHSs. The OHO recognises the state-wide relevance of this report's recommendations and has published it in the hope that learnings can be taken to improve health service delivery to Aboriginal and Torres Strait Islander peoples across Queensland's HHSs. The OHO acknowledges the impact publishing this report may have on front line staff who are often working in uniquely challenging circumstances.

[2] Queensland rural and remote health service framework.
[3] Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services QHRC: Health equity.

The OHO also acknowledges the additional impact Covid-19 has had, and continues to have, on the provision of health services in rural and remote areas.

Figure 1: Map of Queensland highlighting Doomadgee



3. Background information

3.1 Complaint

On 8 July 2021, the Health Ombudsman received a complaint from the legal representative of Mr Edgar Sandy about the death of Miss Sandy on 30 May 2020 and the health services provided by DRH, including to the Doomadgee Aboriginal community generally.

Mr Sandy raised the following issues in relation to DRH:

- failed to escalate Miss Sandy's care to Mt Isa or Cairns earlier
- inappropriately discharged Miss Sandy on 29 May 2020
- refused Miss Sandy's elder female relatives, who had cultural responsibility to care for Miss Sandy, access to the hospital
- had insufficient clinical staff present on 30 May 2020 when Miss Sandy deteriorated
- inappropriately engaged police for assistance with communicating with the Sandy family on 30 May 2020
- required Mr Sandy to deliver the news of Miss Sandy's death to attending family members
- failed to recognise Miss Sandy as a high-risk patient with a complicated medical history who had a greater requirement to manage her care, rather than rely on self-care
- failed to keep adequate and professional clinical records
- failed to provide culturally competent care to Miss Sandy as an Indigenous woman.

Mr Edgar Sandy's complaint to the OHO requested that the Health Ombudsman investigate the matter and assist Mr Sandy and Miss Sandy's family to understand:

- What happened to Miss Sandy when she was in DRH?
- Was the treatment of Miss Sandy at DRH compliant with the policies and standards set by Queensland Health for the treatment of all Queenslanders?
- Was the treatment of Miss Sandy at DRH compliant with the policies and standards set by Queensland Health for the treatment of Aboriginal patients?
- Why did DRH discharge Miss Sandy on Friday 29 May?
- Given Miss Sandy had a complicated medical history and was a high-risk patient, why did DRH not recognise that there was a greater necessity to manage her care and not rely on self-care?
- Was there an earlier opportunity to transfer Miss Sandy to Mt Isa or Cairns?
- Did the staff have and exercise cultural awareness in caring for Miss Sandy?
- On what basis were Miss Sandy's elder female relatives locked out of DRH?
- Why did a nurse call the police when Miss Sandy was in cardiac arrest?
- In what capacity were the police acting at DRH for the duration of their presence? Were the police acting at the direction of DRH when they questioned Mr Sandy while he was mourning the death of Miss Sandy? Why did DRH provide confidential health information to the Police during Miss Sandy's admission without the consent of Miss Sandy or Mr Sandy (as her next of kin)?
- Why did medical staff require Mr Sandy to deliver the news of Miss Sandy's death to attending family members?
- What has happened to the Queensland Health investigations into other recent deaths at DRH that were promised in late 2019? Have those investigations been completed, what were the findings, and what improvements will be made at DRH as a result of those findings?

4. Investigation

4.1 Scope of the investigation

The scope of the investigation, based on the concerns raised in the complaint, was refined following assessment of clinical records and input from Dr Mark Wenitong,[4] as follows:

Whether DRH:

1. Has adequate staffing levels and appropriateness of training including appropriately inducting locum staff of the facility and cultural considerations given its remote location and mostly Indigenous community.
2. Has appropriate policies and procedures for record keeping which staff are compliant with and use culturally safe language within the records.
3. Has and follows appropriate management pathways for chronic disease including RHD in line with the *Australian Guideline for prevention, diagnosis and management of acute rheumatic fever and rheumatic heart disease* (the Guidelines).[5]
4. Has appropriate emergency/after-hours access to DRH
5. Has appropriately managed Miss Sandy's care from her engagement with the health service until her passing, including:
    a. the management of her mechanical valve replacement
    b. education and discussions around 'non-compliance' with medication
    c. appropriately engaged allied health services where necessary, such as Indigenous Liaison Officers for continuity of care
    d. her discharge on 29 May 2020
    e. the escalation of her care and resuscitation on 30 May 2020.
6. Has appropriate policies and procedures governing clinical incident management and open disclosure processes, particularly with cultural considerations for Indigenous persons.

Although the scope of the investigation has been refined, the OHO has also endeavoured to address the range of questions and concerns raised in the complaint.

[4] Dr Mark Wenitong is from the Kabi Kabi tribal group of south Queensland and a registered medical practitioner with a special interest in improving the health outcomes for Aboriginal and Torres Strait Islander people across Australia. Dr Wenitong is a Medical Advisor at the Apunipma Cape York Health Council and is a past President and founder of the Australian Indigenous Doctors' Association. Dr Wenitong was previously the Senior Medical Officer at Wuchopperen Health Services in Cairns, acting CEO of the National Aboriginal Community Controlled Health Organisation and Medical Advisor for the Office of Aboriginal and Torres Strait Islander Health in Canberra.
[5] ARF RHD Guidelines 3rd Edition (rhdaustralia.org.au)

4.2 Investigation process

The investigation process included:

- identification of key issues and scope of investigation utilising early clinical advice
- correspondence and requests for information made by the OHO to NWHHS
- receipt and review of information provided by NWHHS
- research relating to legislative and operating frameworks
- review of *'Betty's Story: a review of the care received by a young woman with Rheumatic Heart Disease'* and the implementation of recommendations from this report—the OHO became aware of Betty's Story and the recommendations arising from the report during the investigation process and identified it as a relevant case study
- receipt and review of expert clinical advice reports from Dr Wenitong and Dr Samuel Stevens[6]
- receipt and review of information provided by the Office of the Northern Coroner
- analysis and development of findings.

5. 'Betty's Story'—relevant investigation

Approximately eight months prior to Miss Sandy's passing, another young woman passed away from RHD in DRH. Yvette 'Betty' Booth's death sparked a community protest in Doomadgee on 30 September 2019, with Queensland Health advising it would hold an investigation into the death.

Information from Betty's story has been included in this report as it is in the public domain, and following consultation with her family

Yvette 'Betty' Booth had a history of frequent presentations to health service providers with high heart rate, fever, shortness of breath and a cough and was diagnosed with asthma. Investigations at the age of 8 found her heart and heart valves to be normal and a respiratory review at 14 years old reconfirmed her diagnosis of asthma. In July 2019, during a screening program in Doomadgee, Betty was diagnosed with RHD with severe mitral valve regurgitation, and it was noted she would require surgery. The plan for Betty's primary care was handed over to GH, with a referral to the Indigenous Cardiac Outreach Program (ICOP).

Following Betty's diagnosis on 26 July 2019, she had 12 presentations to DRH with shortness of breath, cough, and fever. DRH had no information on Betty's diagnosis of severe RHD until 5 August 2019. On 23 September 2019, Betty presented to DRH acutely unwell and passed away early that evening before she could be transferred to a higher acuity facility. Betty was 18 years old.

Betty's family and members of the Doomadgee community voiced concerns regarding the services being delivered in Doomadgee and NWHHS undertook to commission an independent review of Betty's care. An investigation was conducted, and a report[7] produced which made 10 recommendations. The report noted that Betty's journey following her diagnosis of RHD was particularly complex with at least 8 services touching her referral to ICOP in some way, however, the level of urgency attached to the referral and where responsibility sat for coordinating, managing

[6] Dr Stevens is a currently practising Queensland Rural Generalist who holds General and Specialist registration with experience working and living in the rural Queensland as the Medical Superintendent of Cherbourg and Murgon hospitals. Dr Stevens has advanced skills in Aboriginal and Torres Strait Islander Health and continues to provide emergency care to patients arriving at Kingaroy Hospital.
[7] North West Hospital and Health Service, March 2020, Betty's Story: a review of the care received by a young woman with Rheumatic Heart Disease.

and/or monitoring Betty's care and her referral appeared to be unclear with services mostly operating in isolation of each other.

'Betty's Story' notes that the review of the circumstances of Betty's passing was limited due to time constraints, information that was available[8] at the time and the emergence of Covid-19 which impacted on the ability to obtain additional specific information, namely an interview with Retrieval Services Queensland staff. It was also noted that the review did not include:

- a medical or cardiology review of the clinical care and/or treatment provided to Betty
- a comprehensive assessment of local health service operations or an accreditation of health service delivery standards—it also did not test compliance with national standards
- any assessment or opinion on performance.

The scope of the review was to investigate matters relating to the clinical and cultural safety of care provided to Betty as relevant to her diagnosis of RHD in 2019 including the following:

1. assessing the clinical care provided against accepted pathways/guidelines/standards
2. assessing the effectiveness of communication among service providers and between service providers and the patient and their family
3. assessing the cultural safety of the care provided to the patient and family
4. assessing the systems related to the acute respiratory syndrome and RHD care for this patient and comment on how this could be improved
5. commenting on the response put in place by the NWHHS immediately following the event to address concerns raised and support the family and HHS staff
6. making recommendations for future actions to strengthen the quality of care for the Doomadgee community.

5.1 Recommendations from 'Betty's Story' and their implementation at NWHHS

Information received from NWHHS in February 2022 indicates most of the recommendations from 'Betty's Story' are yet to be fully implemented. Of the 10 recommendations, only 1.d., 1.e., 2.b., 9.a. and 9.b. are marked as completed. Significantly, recommendation 3 relating to early detection and screening programs for RHD, and the follow up and clinical handover protocols following these programs, was highlighted and it was noted that the plan for future screenings was yet to be developed. This is significant in the context of 'Betty's Story' where there was criticism regarding the follow up and coordination of Betty's care following her diagnosis during an RHD screening program. The OHO received no information regarding the status of the implementation of recommendations 6, 7, 8 and 10, which overwhelmingly related to cultural considerations, communication and community engagement. These concerns are repeated in Mr Sandy's complaint to the OHO.

[8] The review was noted to have been conducted over an 8-week period commencing Monday 3 February and it was noted in 'limitations and caveats' section of report that some clinical records could not be located in time, and some interviews could not be undertaken due to COVID-19.

6. Miss Sandy's timeline

Miss Sandy was diagnosed with rheumatic fever during childhood and consequently she had numerous engagements with health service providers over her life. The table below is a summarised timeline of significant presentations and comments from the records gathered. Only relevant and significant records are reproduced, and a more detailed timeline is included in Appendix 1.

Source	Date	Notes
	1983	27 March – Date of birth
DRH	1988	November – First entry in DRH records. Presented to hospital with vomiting - impression of viral gastro. Noted that rheumatic fever diagnosed in Tennant Creek.
DRH	2009	May – To Dr Christian Hamilton-Craig, Cardiologist, The Prince Charles Hospital (TPCH) "In view of her residence in Doomadgee and multiple other family members having had rheumatic heart disease, I think that in the context of this young lady, it's probably reasonable to consider mechanical MVR[9] as I think she's reasonably sensible and will adhere to Warfarin which I discussed extensively with her today." October – The Prince Charles Hospital Heart Operation Report "An extensive pre-operative discussion was undertaken and she elected to have a mechanical mitral valve replacement, being well aware of the risks associated with Warfarin into the longer term."
DRH	2015	March – hospital admission for subtherapeutic anticoagulation. September – Doomadgee cardiology outreach clinic. Indigenous cardiac outreach program: "Pt has said she has not had her Bicillin tablets since last year as she is met with barriers every time she presents to the hospital for the script re emergencies requiring her to wait."
DRH	2017	23rd May – brought in by Queensland Ambulance Service (QAS) with "Altered mental state/neurological symptoms – weakness". Referral letter to Mount Isa Base Hospital (MIBH): "Non-compliant!!!!! The patient has not taken the medication listed below in OVER 12 months!!!!!!" Transported by Royal Flying Doctor Service (RFDS) to MIBH.
MIBH	2017	Discharge summary (admission date 24/05/2017) "Patient non compliant with Warfarin which will be the best preventative for further TIA[10] and stroke – explained to pt the importance of this and referred ALO team to help assist and discuss compliance in the community."
DRH	11/10/17	October – admitted with diagnosis of CVA[11] (11th), discharged at own risk (12th).
DRH	2018	February – TPCH, Metro North Hospital and Health Service (MNHHS) – Dept of Cardiology, Doomadgee cardiology outreach clinic

[9] Mechanical valve replacement.
[10] Transient ischaemic attack.
[11] Cerebrovascular accident.

Source	Date	Notes
		"she is taking her medications intermittently. The last time she took her tablets was two weeks ago. I note that in May last year she had a TIA in the same setting. I tried to educate her again today…Given that she has poor compliance with her medications, I would be keen to continue only Warfarin…" "We have to think about a mechanism of how we make sure she is compliant with her treatment." October – Doomadgee cardiology outreach clinic "Unfortunately, her non-adherence with her Warfarin has been the recurrent theme of her management over the past few years. Fortunately, she has not had a major event, in particular mechanical valve thrombosis, over the past few years despite her non-adherence."
DRH	2019 (Feb to July)	February – Doomadgee cardiology outreach clinic "Unfortunately, compliance remains the issue for her. She is unable to recall when the last time she had Warfarin therapy was. She doesn't have any warfarin at home at the moment. The most recent INR[12] that I can see in the chart was done about two weeks ago and was 1…otherwise she has no symptoms of heart failure and no chest pain." May – Gidgee Healing notes she has not had any medication for many months and Miss Sandy happy for GH to take over care from DRH.
GH	2019	7th November – presented to Gidgee Healing (GH) for INR (8).
QAS (Queensland Ambulance Service)	2019	12th November – QAS – eARF[13] "36 female with 9/10 lower abdominal pain…pt saw own dr and is waiting for results…Pt refused analgesic. Pt tachycardia, all other VSS[14] within normal parameters."
DRH	2019 (Nov)	12th November - Medication chart shows medications administered to Ms Sandy including Buscopan, Paracetamol, Lactulose and Glycerol suppository. 15th November – notes reflect "seen here on 12/11 with abdo distension and poorly localised pain…asked to return daily for INR, failed to present despite several reminders (husband also works for GH!)". Transferred by RFDS to MIBH.
MI	2019	16th November – noted conflicting history from doctor notes and patient. "Patient sure that she visited GP on 8/11/19. INR was 8. Stopped warfarin 9/11/19. Visited GP for repeat INR on 11/11/19, unable to recall results. Stopped warfarin 11/11/19 till date. 23rd November – Discharge summary – ""Decided to discharge patient with clexane instead of warfarin as she would need bridging if she would proceed with surgery in Dec."
DRH	2020	January – Specialist outpatient referral to Dr Umayal Lakshman (medical) "well known RHD patient that was lost to follow up with medical and cardiac team. Dr Kalum has discussed this patient with Dr Uma. For review in outreach clinic." February – Medical outreach – Dr Lakshman/Schmidt/Sabu.

[12] International normalised ratio—a measure of the time for the blood to clot.
[13] Electronic Ambulance Report Form.
[14] Vital signs stable.

Source	Date	Notes
		27th May – 8pm admitted to ward with atrial flutter, case discussed with Mt Isa and plan for admission overnight on cardiac monitoring. 29th May – ward round with medical officer (MO) noted "ok overnight. This morning c/o some epigastric discomfort + nausea. NO for few days." Discharged summary notes: ▪ "c/o subjective SOB[15] a few hours, palpitations. No chest pain/cough/URTI[16]" ▪ "Poor warfarin compliance, chronic issue" ▪ "o/e GC good. Not distressed. P=140 irreg BP=95/65 Sats=92%RA. Afebrile" ▪ "ECG: Aflutter with 2:1 block @ 140bpm. Trop=0.15. Chem 8 unremarkable" ▪ "Reverted to sinus rhythm after these measures, and SOB resolved. Likely Type 2 trop leak – d/w Dr Kallam, Mt Isa Med Consultant – agrees." Recommendations to GP: "F/U re Warfarin management. Does seem rather sensitive to Warfarin & note previous severe bleed from high INR." 30 May – brought in by QAS with "abdo pain, SOB, and rapid AF. QAS unable to get radial pulse or B/P". Noted "Discharged from DMG Hospital after brief episode of AF, which revered quickly after one dose of IV MgSO4. Was inpatient for 2 further days to re-commence on Warfarin. On discharge 36hrs ago, INR=3.9. Given NO further warfarin since then." "Possible Intra-abdominal bleed, given abdo pain & PMH[17] & INR ?high; Possible cold Sepsis; Possible embolic episode with Bowel Ischaemia? …d/w ED SMO in Mt Isa – agress [sic] with current regime and accepted for T/F. d/w RSQ[18] – accpted [sic] for retrieval." "a few seconds later [at 1715] after telling the patient what RFDS had said, the sclera of both eyes, went red patient became unresponsive, CPR started by RN Edward". "1815pm – cpr stopped, Patient partner brought in and MO spoke to partner".

[15] Shortness of breath.
[16] Upper respiratory tract infection.
[17] Past medical history.
[18] Retrieval Services Queensland.

7. Findings

Some differences in the accounts that Miss Sandy's family provided were noted during various stages of the investigation. Where there is any discrepancy, evidence is relied upon from the complaint made by Mr Sandy via his legal representative.

7.1 Staffing levels and appropriateness of training, including staff induction and cultural considerations

7.1.1 Issues identified in complaint material

Mr Sandy's complaint raised concerns that there was inadequate staff present at DRH as staff were witnessed rushing to the hospital during Miss Sandy's deterioration on 30 May 2020. Mr Sandy's complaint also details concerns regarding the cultural capability of staff at DRH and their clinical management of Miss Sandy over the course of her life, suggesting deficiencies in the induction and training of staff.

7.1.2 Analysis of issues

The complaint to the OHO raised concerns regarding a number of clinical decisions, instances of record-keeping, staff professionalism, adherence to policies, observance of cultural sensitivities and communication spanning years of Miss Sandy's treatment, suggesting deficiencies in staff training across the service.

Information obtained from DRH indicates that the hospital had 24-hour access to a registered medical practitioner and on-site RNs. It is understood that the Director of Nursing (DON), who commenced in the role prior to Miss Sandy's passing, has the appropriate qualifications as required for a level 2 hospital, and at the time of Adele's passing on 30 May 2020 there were 3 registered nurses rostered at Doomadgee Hospital. Medical practitioners reside in accommodation next to DRH while they are rostered on and are available on-call after hours. The medical practitioner on-site at the time of Miss Sandy's deterioration had training in advanced trauma life support, clinical emergency management and airway management skills. DRH also has access to Mount Isa clinical staff via telephone, including after hours. Information obtained from DRH staff stated an Indigenous Liaison Officer (ILO) or Aboriginal Health Worker (AHW) is available during the week, and after hours via telephone, and that this was available at the time of Miss Sandy's passing.

In Dr Stevens' report to the OHO, he acknowledged the extreme difficulties faced in recruiting health professionals to remote communities, particularly long-term, and the accompanying reliance on locum doctors and nurses who can have fleeting contact with the community. Dr Stevens opined that the medical officer at DRH for Miss Sandy's May 2020 presentations was appropriately trained to treat Miss Sandy and that staff involved in her resuscitation efforts on 30 May 2020 showed evidence of complying with appropriate Advanced Life Support training. He also noted that Miss Sandy was provided with care that met the appropriate standard during her cardiac arrest on 30 May 2020.

Information obtained from interviews with DRH staff detailed that, although current staff have completed training on RHD, it is not considered 'mandatory' training by NWHHS. It also details extensive weeklong orientation for new clinicians. However, Dr Stevens noted that while staff receive cultural awareness training, it is only through active engagement with patients and community Elders that clinicians can develop skills in how to apply medical training in an appropriate and culturally safe way. It is significant to note that Dr Wenitong's report identified overall engagement as poor from the perspective of the family and this is the most significant consideration according to the Australian

Health Practitioner Regulation Agency's (Ahpra) National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025 *"Cultural Safety is determined by Aboriginal and Torres Strait Islander individuals, family and community."*

This indicates a need for more targeted training to be developed with designated leaders in the Doomadgee community, that educates staff on local cultural values, beliefs and practices and helps develop skills to deliver culturally safe and appropriate healthcare. The engagement of local leaders to provide guidance and knowledge will assist in building the relationship between DRH and the local community and is recommended in Queensland Health's guidelines.[19] The OHO notes that NWHHS has recently released the North West Health Equity Strategy 2022–2025[20] which lists numerous plans in relation to recruitment and training of staff, and aligns with the OHO recommendations below.

7.1.3 Recommendations

1. DRH continues their progress toward increasing awareness and knowledge of ARF and RHD among all clinical staff who currently, or will, work in locations with a high prevalence of ARF and/or RHD through, for example:
    a. continuing inclusion of an introductory session in the orientation program alerting medical staff, nursing staff and Indigenous health workers to the prevalence of ARF/RHD and what to look for
    b. ensuring clinical staff complete the on-line healthcare professional modules available through RHD Australia as a mandatory part of their clinical orientation
    c. provision of an annual schedule of staff and patient education through the Queensland RHD Registry Office to clinical staff.
2. Provide clinical staff with access to tools that assist them to appropriately detect ARF/RHD by making the RHD Australia 'Guidelines and Diagnosis Calculator' which is in the form of an electronic application (App) for iOS and Android devices available on NWHHS devices, and informing clinical staff. This App provides a text and visual reference for each technical stage of a diagnosis. It is designed to minimise diagnosis error and inconsistency and also filters out cases that aren't rheumatic fever so that a clinician is not over-diagnosing.
3. Doomadgee Rural Hospital continues to develop orientation packages and materials that support culturally safe and responsive practice, including exploring the application of these orientation packages for the transient workforce to meet minimum cultural safety standards. This should include:
    a. Engaging with the local Shire Council, Traditional Owners, local community members and appropriate community groups about their experiences to ensure orientation material highlights local community needs, cultural values, beliefs, and practices to assist with strengthening the relationship between Doomadgee Rural Hospital and the Doomadgee community.
    b. Including this orientation as part of mandatory education for completion by all staff during the first month of employment and keeps accurate records of staff completion of this competency.
    c. Seeking and evaluating feedback from community as a measure of cultural safety across service delivery, and working with community to develop and implement improvements to enhance cultural safety.

[19] Sad news, sorry business - Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying (health.qld.gov.au)
[20] nwhhs_health_equity_strategy_final.pdf (os-data-2.s3-ap-southeast-2.amazonaws.com)

d. Including a local Aboriginal community member on staff selection panels for higher grade positions. This may necessitate the establishment of a list of appropriate local Aboriginal community members who would be suitable and willing to be included on staff selection panels.

4. Continue to jointly engage with clinical staff and community leaders to explore what would make local health services more welcoming for patients and Doomadgee a place staff enjoy working and want to stay. This could include conducting interviews with staff as an information gathering exercise to inform a deeper understanding of the organisation and provide insight into why employees initially come to community, why they leave and what might be done differently to retain employees.

7.2 Record keeping (compliance and appropriate language)

7.2.1 Issues identified in complaint material

Mr Sandy's complaint raised concerns about the lack of, or poor, record keeping as well as the cultural sensitivity and professionalism of DRH staff based on entries recorded in Miss Sandy's file. Notable examples of concerns raised regarding record keeping include:

- Miss Sandy's presentation at DRH on 12 November 2019 is only identified retrospectively from clinical records dated 15 November 2019
- clinical notes during Miss Sandy's admission between 27 May 2020 and 29 May 2020 are brief and uninformative
- there is no discharge summary for Miss Sandy on 29 May 2020
- there is no record of Miss Sandy's presentation at DRH around 21-23 May 2020, as recalled by her family
- Miss Sandy's records contained comments that conveyed judgemental, negative and unconstructive attitudes held by DRH staff towards her, for example on:
  - 20 July 2010 "Hasn't had Warfarin for 7/12…INR 1.0. Not a surprise."
  - 23 May 2017 "The patient has not taken the medication listed below in OVER 12 months!!!!!!".
  - 15 November 2019 "…asked to return daily for INR, failed to present despite several reminders (husband also works for GH!)".
  - 30 May 2020 "denies alcohol". This could be interpreted as being indicative of negative assumptions on the part of the practitioner.

7.2.2 Analysis of issues

Clinicians are required to maintain contemporaneous and accurate records of the care they provide to patients and these requirements are set out in relevant professional standards and codes of conduct for clinicians. DRH is responsible for supporting these obligations through relevant record keeping policies, procedures and systems.

NWHHS has no specific policy regarding appropriate language, including culturally appropriate language, to be used in clinical records, however their Procedure for Clinical Documentation in Patient Records documents that *"Entries in the clinical record shall not include assumptions, suppositions, or personal opinions/conclusions/inferences. Documentation in the clinical record shall uphold the dignity of the patient and demonstrate respect for the patient as well as their family/carer(s). Documentation is to demonstrate continuation of the trust relationship built with the*

patient as well as respect for the patient, sensitivity and cultural support." This procedure further outlines the minimum standards for documentation including what information should be documented.

Despite the NWHHS procedure outlining that documentation *"shall be a detailed, complete and descriptive account of events"* and shall provide a *"clear account of the healthcare professional's clinical examination of the patient, assessment, clinical reasoning and treatment"*, this investigation has identified deficiencies in DRH clinical record keeping.

Miss Sandy's presentation at DRH on 12 November 2019 is lacking any record of clinical assessment, examination or management plan on this date. A medication chart documents medication administered on 12 November 2019 to Miss Sandy and her presentation is retrospectively identified in clinical records dated 15 November 2019. The lack of records for 12 November 2019 is of note given the concerns raised in the complaint that Miss Sandy presented to DRH between 21–23 May 2020 despite no clinical records to support this presentation. Information obtained during interview with DRH staff indicates that each presentation to the emergency department, regardless of whether it is for non-urgent medication or emergency care, is triaged and recorded.

However, clinical advice from Dr Wenitong notes that DRH's records in the 2 years preceding Miss Sandy's passing were not to the required standard with obvious deficiencies in clinical note keeping. Dr Wenitong provided the specific example of records from 29 May 2020 documenting Miss Sandy's QADDs[21] score as zero in the progress notes when her score was recorded as 2 on the QADDs table. Significantly, Dr Wenitong notes that the medical officer who discharged Miss Sandy may have only seen the progress notes and noted this may or may not have impacted their pre- discharge assessment.

Dr Wenitong noted it was difficult to assess whether staff had racial or attitudinal issues with Miss Sandy, however he did comment that Miss Sandy often did not appear to be prioritised. Dr Wenitong also notes the regular questioning regarding alcohol use when there were reportedly no alcohol problems shows some potential racial stereotyping. Regarding the cultural appropriateness of clinical records, Dr Wenitong advised that progress notes for Miss Sandy such as *"her excuse is that it is hard for her to come into the clinic…"* is not consistent with the NWHHS Procedure for Diversity and Support to Access Healthcare.

Dr Stevens opined that DRH clinical records for Miss Sandy in the two years prior to her passing are *"completely inadequate."* Dr Stevens provided numerous specific examples of concerns regarding the lack of records, particularly during her May 2020 presentations and advised *"of particular concern, I note that the most important clinical document has been left incomplete (i.e., the majority of the ED-QADDS paperwork). Whereas, clinically irrelevant (but bureaucratically required) information such as falls risk, skin inspections and pressure injury risks seem to be completed in entirety."* The NWHHS Procedure for Clinical Documentation in Patient Records notes that one of the purposes of clinical record documentation is to *"provide a record of all plans and transactions relating to provision of care to facilitate continuity of care for the patient"* and concerningly, the sparsity of clinical notation and incomplete documentation was noted to have impacted on both expert clinical advisors' ability to answer questions in relation to Miss Sandy's care. Dr Stevens also noted the difficulty with identification of staff by name and position within the progress notes was also not consistent with NWHHS policies.

DRH in its submission to the OHO dated 2 August 2021 advised that each presentation to the NWHHS has adequate records. This assessment by DRH on the adequacy of the records of Miss Sandy's presentations is not supported by the evidence and expert clinical opinions obtained in this investigation.

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[21] Queensland Adult Deterioration Detection System – an early warning tool to track vital signs and trigger alert systems.

7.2.3 Recommendation

Recommendation 3 above, and:

5. Continue work already undertaken to improve the use of patient information systems by reviewing:
    a. How staff know to access and use various relevant record systems, for example The Viewer, Communicare and paper charts/notes.
    b. Review the effectiveness of the use of triggers/alerts in the various patient information systems used.
    c. A random sample of recent clinical records and evaluate them against the NWHHS 'Procedure for Clinical Documentation in Patient Records' to develop an appropriate action plan for any identified deficiencies.

7.3 Management pathways for chronic disease including RHD in line with Australian Guidelines for prevention, diagnosis and management of RHD

7.3.1 Issues identified in complaint material

Mr Sandy's complaint raised concerns about the quality of the health service provided to Miss Sandy, including the clinical management of her RHD and lack of escalation of clinical care.

7.3.2 Analysis of issues

RHD Australia, based at the Menzies School of Health Research, has produced the Australian guideline for prevention, diagnosis and management of ARF and RHD.[22] The ARF RHD guidelines note that secondary prevention with penicillin prophylaxis is an integral aspect of the management of RHD and adherence to medication improves patient outcomes. Miss Sandy, having undergone a mechanical valve replacement in 2009, also required anticoagulant medication with routine and regular monitoring of international normalised ratio (INR) in the form of blood tests. INR is a measure of the time for blood to clot and is used to monitor anticoagulant medication. The ARF RHD guidelines note the major limitation of warfarin, which remains the only option for anticoagulation following implantation of a mechanical valve replacement, is the requirement for monitoring its therapeutic effect (INR) in the form of regular blood tests. It further recognises the challenge of achieving satisfactory anticoagulation due to language and cultural barriers, mobility of the population, remoteness from pathology services and interactions between warfarin and many commonly used medications and foods.

Dr Wenitong's clinical advice acknowledged that Miss Sandy's issue with compliance with medications was well documented, however there was little recorded on specific medication education and compliance aiding strategies or details on why she was non-compliant. This is of particular significance given instances recorded in the clinical records of technical issues impacting Miss Sandy's INR tests as well as concerns raised by Miss Sandy that she was not prioritised when she attended DRH. The ARF RHD guidelines notes *"where patients miss or decline injections in the short or medium term, health staff and Aboriginal and Torres Strait Islander Community Workers should work with the patient and family to identify and address any manageable factors that may be contributing to unsuccessful secondary prophylaxis delivery."* It is difficult to establish from Miss Sandy's clinical records, whether a discussion was held to identify and address the factors

[22] ARF RHD Guidelines 3rd Edition (rhdaustralia.org.au)

contributing to the documented non-compliance. Dr Wenitong also noted that Miss Sandy's warfarin regime appeared to be extremely difficult to manage for both her and the health staff and that *"even with daily monitoring on some occasions the fluctuations in INR were unusually very variable and this may have complicated the compliance issues."* Queensland Health guidelines for warfarin management in the community[23] recommend increased monitoring in patients more sensitive to warfarin, and Dr Wenitong opined that Miss Sandy would have benefited from a much more proactive approach, as suggested in the RHD guidelines. Dr Stevens was of the view that the documented hospital follow up of Miss Sandy, insofar as INR checks and RHD prophylaxis, was completely unacceptable, ad hoc and with no clear plan for triggering a recall system and how this recall was undertaken.

NWHHS provided a copy of the clinical pathway for suspected acute rheumatic fever used to support the recognition and management of suspected ARF in patients presenting to the Emergency Department. NWHHS staff advised that primary care management of RHD in Doomadgee is administered by GH, who took over this service in 2020, with Queensland Health staff offering support to follow up with patients if required. DRH staff expressed concern to OHO officers regarding:

- the communication between DRH and GH
- the lack of RHD care plans in place that are required as part of a patient's primary health care
- staffing issues within GH which could potentially impact on delivery of RHD clinics.

While primary health has shifted to GH, Dr Wenitong noted in his clinical advice that there is a need for an up-to-date service level agreement between Queensland Health and GH for the coordination of their various services including medication supply and RHD programs. The importance of partnerships between local Aboriginal Community Controlled Health Services and local health districts is discussed in Report no. 57 of the Portfolio Committee No. 2— Health, titled 'Health outcomes and access to health and hospital services in rural, regional and remote New South Wales'.[24] Associate Professor Peter Malouf, Executive Director of Operations, Aboriginal Health and Medical Research Council of New South Wales, explained that in order to ensure that First Nations people receive the highest levels of care and consideration, genuine partnerships must be formalised between Aboriginal Community Controlled Health Services and the Local Health Districts. A submission from Aboriginal Health and Medical Research Council of NSW, received by the Portfolio Committee No. 2—Health, recommended that partnerships should be formal Service Level Agreements, linked to an agreed set of performance indicators that keep all parties accountable. After the passing of the *Health Legislation Amendment Act 2020* Queensland Health, in partnership with the Queensland Aboriginal and Islander Health Council (QAIHC), hosted a Torres and Cape consultation workshop on health equity on 15 April 2021. Following on from this consultation a report[25] was published summarising discussions which noted that there has historically been a lack of trust between community and ATSICCHOs[26] towards Queensland Health, that there was a need to learn from current partnership arrangements which required stronger accountability to the HHS[27] Board and community. The OHO acknowledges NWHHS's recently released Health Equity Strategy[28] which notes their plans to clarify and articulate who will coordinate care for RHD/ARF patients and the OHO recommendation below closely aligns with these plans.

[23] Guidelines for warfarin management in the community (health.qld.gov.au)
[24] https://www.parliament.nsw.gov.au/lcdocs/inquiries/2615/Report%20no%2057%20-%20PC%202%20-%20Health%20outcomes%20and%20access%20to%20services.pdf
[25] QAIHC and Queensland Government, July 2021, *Consultation Report: Torres and Cape regional consultation*, https://www.qaihc.com.au/media/37920/0298-hec-report_torrescape_final.pdf
[26] Aboriginal and Torres Strait Islander Community Controlled Health Organisations
[27] Hospital and Health Service
[28] North_west_health_equity_strategy_2022-2025.pdf (os-data-2.s3-ap-southeast-2.amazonaws.com)

7.3.3 Recommendations

6. Continue work already implemented regarding protocols for the conducting of early detection or screening programs, and ongoing management of identified patients, in the NWHHS that include:
    a. A member of screening team visiting the community prior to and after the screening to work with Gidgee Healing and the hospital to educate staff and set up systems for follow up.
    b. Appointing a local coordinator who will have responsibility for ensuring:
        i. there is a clinical debrief held with the screening team to share diagnosis and prioritise actions with:
            A. hospital doctor(s) and nursing staff
            B. Gidgee Healing, or other service as appropriate.

            If staff are not at the debrief, ensure information is shared with those individuals within 1 working day of the debrief.
        ii. copy of the screening results is provided to Gidgee Healing and the HHS
        iii. screening results are entered into Communicare notes within 1 working day of the debrief
        iv. ongoing education provided to those children and families with a confirmed diagnosis
        v. education on RHD is provided to clinical staff (regardless of screening results)
        vi. each person identified with RHD has someone nominated to coordinate their care and a personal management plan with a copy of the management plan located in records held at the hospital and Gidgee Healing
        vii. a care plan (detailing what needs to happen, when and by whom) is compiled in accordance with the National RHD Guidelines and monitored through the morning meetings. Ensure responsibilities are clear:
            A. local medical assessments and reviews are scheduled and completed as required
            B. referrals to specialist services are completed and appointments confirmed within the required timeframe
            C. attendance is facilitated
            D. medication is ordered, commenced and monitored
            E. notification to the RHD registry is completed.
    c. Seeking and evaluating feedback from the community and staff regarding the programs implemented.
7. Consider how case reviews of patients who frequently present with similar symptoms and/or with complex needs could assist to improve health outcomes.
8. Doomadgee Rural Hospital partners with Gidgee Healing to ensure effective collaboration and coordination regarding each patient's health care journey to ensure integration of care. This will require:
    a. Doomadgee Rural Hospital working proactively with Gidgee Healing to develop a set of working principles for a local service partnership agreement that covers reciprocity (for the benefit of the Aboriginal community), communication, involvement and knowledge. This partnership should be formalised through a local service agreement, formal representation in governance structures and regular meetings that have defined reporting processes ensuring there is clarity and coherence about responsibilities for all aspects of health service

delivery.[29] All health services to have full knowledge of principles and priorities for service provision and coordination.

b. Promotion of improved communication between service providers as part of the local service partnership.[30] This would be achieved through review of any existing communication pathways, identifying and implementing any improvements for information sharing as patients move from one service to another to ensure an individual's engagement with the health system in the community is as seamless as possible. Where consent is given, all health services must have access to current patient information including new diagnosis, investigation and/or health assessment findings, care plans, medications and referrals made.

c. Creation of a local service agreement (LSA) (in a above) which includes documentation of service delivery responsibilities and expected outcomes for each service and how they work together.

    i. This LSA should include development and consultation with Gidgee Healing and other community health service providers to develop and implement a framework for community consultation. This process must seek input from appropriate community representatives including the local Shire Council and other appropriate community body/bodies, either existing or newly established, to ensure genuine community consultation on local health service design, delivery and evaluation, and community communication strategies. This committee should be tasked with:

        A. developing terms of reference, a meeting schedule (no less than quarterly), recording and distribution of minutes and action items

        B. consultation regarding culturally safe healthcare design, delivery and evaluation, and communication solutions that work best for the community to ensure critical information and alerts are communicated and received in a timely manner[31]

        C. monitor and evaluate progress of agreed outcomes, using data and information to drive change where necessary.

d. Seek, record and review feedback regarding the LSA from the community.

e. Review any existing communication pathways between Gidgee Healing and the NWHHS, particularly the structure and format of the morning inter-service meetings to allow:

    i. Representatives of all clinical groups from each local service, the Nurse Navigator Service and any other service regularly involved in the care of patients to be part of any discussion around the care that is needed and/or provided to patients.

    ii. All services in (i) above to have full knowledge of the agreed priorities and which service is coordinating the associated plans of care, or specific actions within those plans.

    iii. All local services to have current patient information including new diagnosis, investigations and/or health assessment findings, care plans, medications and referrals made.

    iv. Promotion of improved communication between service providers. This would be achieved through identifying and implementing mechanisms for information sharing as patients move from one service to another to ensure an individual's engagement with the health system in the community is as seamless as possible. Where consent allows,

[29] National Safety and Quality Primary and Community Healthcare Standards (NSQHS) 3.19 Multidisciplinary collaboration.
[30] NSQHS 3.27 Communication to support patient referral and multidisciplinary collaboration.
[31] NSQHS 3.29 Communication of critical information.

all services have access to current patient information including new diagnosis, investigation and/or health assessment findings, care plans, medications and referrals made.

9. Continue work already undertaken to establish a consistent approach to applying the national ARF/RHD guidelines, including clarifying and articulating:
    a. Who will coordinate care which includes:
        i. completing and monitoring (including reviews) a personal care plan with the patient and placing a copy of the care plan in records held at the hospital, community health and Gidgee Healing
        ii. scheduling local medical or health assessments and reviews and making sure they occur
        iii. completing referrals to specialist services for review
        iv. monitoring and enacting changes in care made by specialist services
        v. coordinating arrangements for appointments to external services
        vi. monitoring the ordering and administration of medication.
10. Establish open communication channels when a seriously ill patient presents for care by:
    a. continuing to review the use of Indigenous Health Workers and explore the feasibility of an expanded role where they provide a link between clinical staff and family members when a seriously ill patient is being treated at the hospital
    b. exploring with the Doomadgee community how individuals and families may be supported when they are receiving treatment at the hospital for serious illness.

7.4 Emergency/after-hours access

7.4.1 Issues identified in complaint material

Mr Sandy's complaint raised concerns that the doors to DRH are kept locked to members of the Aboriginal community. Mr Sandy also raised specific concerns regarding the exclusion of Miss Sandy's elderly female family members, who had the cultural responsibility to care for her, from DRH during her presentations in May 2020.

7.4.2 Analysis of issues

Submission from NWHHS advised that although there were visitor restrictions in place due to COVID-19, NWHHS did not limit visitors to Miss Sandy between 27 May to 30 May 2020.

Information obtained from NWHHS staff indicates doors to the hospital are kept closed due to the risk of stray animals gaining entry to the hospital. Doors are also locked overnight for security reasons, with a button to press to alert staff on arrival. NWHHS staff advised they did not refuse entry to Miss Sandy's family at any stage during her May 2020 presentations and have no recollection of whether there was any family inside the hospital on 30 May 2020 prior to Miss Sandy's passing, other than Mr Sandy.

'Betty's Story' details at the time of the report, DRH had a small anteroom referred to as "the cage" which served as a waiting room for the medical officer's consulting room. This room had a fine metal mesh screen which consumers would need to speak to DRH staff through and items would be passed through a small opening at the base of the mesh screen. It was noted this room was the subject of considerable discussion between the Doomadgee community and NWHHS and work was undertaken to make the DRH reception area more accessible to the community.

Dr Wenitong's advice comments, *"there seems to be no apparent reason to not allow relatives in the waiting room of the hospital, unless there were not good relations between the hospital and community as perceived by the family of the deceased. Whether there were no relational problems according to hospital staff or not is not as important as what the community and family perceived."* Dr Wenitong also notes that *"whether the family were not allowed in the clinic, or "felt" they were not welcome in the clinic are both cultural safety issues."*

Dr Stevens also noted that even with COVID-19 restrictions in place, there is flexibility in visitor restrictions to allow support persons into facilities in serious situations and it is the clinicians duty to provide leadership and always ensure patients and family experience comfort and dignity. He also recognised the nature of 'support' for Aboriginal and Torres Strait Islander peoples is community based and from multiple members of the wider family. Dr Stevens opines that it is culturally acceptable support to allow these community members to be present.

Regarding communication between Miss Sandy's family, DRH staff and QPS officers, it is difficult to determine what communication occurred between parties, or how information was communicated or understood by individuals, particularly in situations where the health of a loved one deteriorates, and parties are experiencing considerable stress. However it is reasonable to assume that part of the legacy of "the cage" is the local community perception of the inaccessibility of DRH, especially where wildlife and security concerns necessitate the entry door to be closed or locked at times. Dr Wenitong opined that *"being able to access the waiting area should be proactive, and family should have been invited in."*

7.4.3 Recommendation

Recommendations 1-10 as above.

11. Review the accessibility of DRH, with particular focus on accessibility after hours, by:
    a. seeking, recording and reviewing feedback from the local Shire Council, appropriate community groups and local community members as consumers regarding the accessibility of DRH, including what would make it more welcoming and culturally safe
    b. reviewing the security measures in place at DRH
    c. engaging with the local Shire Council and appropriate community groups to explain the requirement for security measures for staff and patient safety and improve awareness of accessibility of DRH despite these security measures.

7.5 Miss Sandy's care

7.5.1 Issues identified in complaint material

Mr Sandy's complaint raised concerns regarding the adequacy of the health care provided to Miss Sandy at DRH, including the lack of recognition of her deterioration and appropriate escalation of care as well as inadequate regard to the socio-cultural factors affecting her. Specific concerns included that DRH staff routinely made assumptions that she was non-compliant with her medications, and this detrimentally affected their approach to her treatment.

7.5.2 Analysis of issues

Miss Sandy had extensive presentations at various health service providers over her life. While concerns were raised regarding her most recent presentations and sudden deterioration at DRH in May 2020, it is important to view previous presentations to complete the picture of her health as well to determine if any prior management may have influenced her care or expectations of care. Consequently, expert clinical advice was sought by the OHO on Miss Sandy's care and her complete records from DRH provided with instructions to provide comment on her care for the two-year period from May 2018 to May 2020, but to also review her entire history and detail any significant concerns raised outside of this suggested timeframe.

Issues relating to Miss Sandy's medication are discussed in 7.3 above and it should be noted that Mr Sandy's concerns regarding DRH's documentation of her 'non-compliance' were mirrored in the expert clinical advice. Dr Steven's commented that *"use of words and phrases such as 'non-compliant' and 'she did not present [for review]' are of particular concern and give an overall feel of medical paternalism and limited understanding of the unique issues faced by [Aboriginal and Torres Strait Islander] patients."* As discussed above, there is very limited documentation in the clinical records that there was any investigation or discussion regarding Miss Sandy's current psychosocial conditions or barriers to improving healthcare delivery, as recommended in the Australian RHD guidelines. Dr Stevens notes his appreciation of the development of a strict 'Failure to Attend' policy by Queensland Health in managing wait lists but finds that it fails Aboriginal and Torres Strait Islander patients completely.

Dr Wenitong's opines that Miss Sandy appeared not to have been prioritised and the frequent questioning of alcohol intake potentially shows "*some racial stereotyping*". While he notes it is difficult to assess whether staff had racial or attitudinal issues with Miss Sandy, Aboriginal people are very aware of whether they are really welcome or not. In the NWHHS submission to the OHO they advised NWHHS are open to any direct feedback from the Sandy family regarding how cultural responsiveness can be improved from their perspective. The OHO expects HHSs to seek and review

feedback from families in these circumstances in order to provide culturally safe and appropriate care.

In relation to Miss Sandy's May 2020 presentations to DRH, there is a lack of documentation regarding whether she was offered, or attended upon by, an ILO or an AHW. Her presentation on 27 May 2020 was mid-week and as such an ILO and should have been available. 'Sad News Sorry Business' documents that an ILO should be contacted on admission, and their advice should be sought when planning care for the patient during their stay and on discharge. It was recognised by both expert clinical advisors that this did not appear to have occurred despite Queensland Health policies recommending their involvement. It is documented in 'Sad News Sorry Business' that ILOs *"will be able to determine the cultural appropriateness of care and provide a vital medium between the health care team, the patient and their family."* This is of particular significance given the Sandy family's concerns regarding Miss Sandy's discharge on 29 May 2020 and as Dr Stevens notes*, "it is disappointing that Mrs Sandy's family were not involved with her discharge process…enlisting family members in decision making processes provides support for treating clinicians."*

The NWHHS submission to OHO states that Miss Sandy was discharged on 29 May 2020 as her condition had improved slightly, she requested she be allowed to return home, and this was approved by the medical officer on the condition that she return in the morning. Both expert clinical advisors raised concerns regarding the lack of a clear and documented discharge plan which affected their ability to determine the appropriateness of her discharge on 29 May 2020.

The involvement of an ILO/AHW would have assisted in the cultural safety of the care provided to Miss Sandy and her family and, particularly in the absence of clear and complete clinical records, assisted in Miss Sandy's family's understanding of her clinical condition and treatment. Information obtained from DRH staff provides that ILO/AHW are available during the week and after hours via telephone, and it is unclear why there is not a greater utilisation of this service in Miss Sandy's records, particularly in light of the documented concerns regarding Miss Sandy's 'non-compliance' or lack of engagement with DRH. Expert opinion is clear that the care provided to Miss Sandy by DRH appears to have been reactive rather than proactive and that basic patient support and systematic chronic disease care was lacking.

7.5.3 Recommendation

Recommendations 1-11 as above.

7.6 Clinical incident management and open disclosure processes, particularly relating to cultural considerations for Indigenous persons

7.6.1 Issues identified in complaint material

Mr Sandy's complaint raised concerns that a nurse at DRH ceased resuscitation efforts on 30 May 2020 to call police and he questioned the cultural competency of the care provided to Aboriginal patients by DRH given the deployment of police in a clinical setting. Mr Sandy believes the police were acting as security and as a conduit for communication to the Sandy family at the request of DRH. The complaint details that the Sandy family were not provided any explanation for Miss Sandy's clinical deterioration or cause of death at the time of her passing and two subsequent meetings between DRH staff and different members of her family also failed to provide answers.

7.6.2 Analysis of issues

Queensland Health first published 'Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying'[32] in 2011. The guidelines detail customary practices vary between and within Aboriginal and Torres Strait Islander tribal groups and that wherever possible, hospitals are encouraged to establish specific local guidelines in partnership with their local communities to ensure appropriate, culturally competent care.

Importantly, as noted in the Nursing and Midwifery Board's code of conduct for nurses, *"to ensure culturally safe and respectful practice, nurses must understand that only the person and/or their family can determine whether or not care is culturally safe and respectful.[33]"*

NWHHS, in their submission to OHO in response to Mr Sandy's complaint, denied contacting the police or using them to communicate with the Sandy family. They have advised police were contacted by a community member who told police Miss Sandy had contracted Covid-19 and their presence was part of the QPS Covid-19 risk management. During interview with DRH staff, it was noted that it was usual practice for DRH to contact 000 for paramedic assistance with resuscitation. In Miss Sandy's case, DRH staff noted they contacted 000 for assistance, noting that paramedics had only recently left after dropping her at DRH, and that QPS were notified through the 000 process. DRH staff denied that they directly contact QPS to assist with resuscitation, as there was sufficient staff. Dr Wenitong notes in his advice that the use of police to communicate updates regarding medical treatment to relatives is both unethical and poor socio-cultural practice in most Aboriginal communities. In particular, the presence of police compounded mistrust in the context of the specific local history involving the Doomadgee community and DRH. Dr Stevens was not critical of the decision of DRH staff to contact emergency services for assistance with resuscitation and opined that QPS officers commenced an investigation on their own initiative as part of their reporting process to the coroner. While there is confusion regarding the role QPS played on 30 May 2020, clinical advice suggests that from a cultural safety perspective, in the context of Doomadgee's local recent history, DRH should have been aware of the impact of police presence and taken active steps to address the impact of police presence.

As discussed above, 'Sad New, Sorry Business' recommends contacting ILOs on admission as well as seeking their advice when planning care during their stay and on discharge. Dr Wenitong notes that DRH's engagement with Miss Sandy's family was poor from the perspective of the family and remarks that this is what counts from a cultural safety perspective. Dr Wenitong was critical of DRH's lack of utilisation of a liaison officer during Miss Sandy's May 2020 presentations, and although 30 May 2020 was an emergency presentation, he noted that there was time to call the liaison officer. The engagement of a liaison officer following Miss Sandy's passing would have been in line with 'Sad News, Sorry Business' recommendation of the consideration of coordinating care with the Aboriginal and Torres Strait Islander Hospital Liaison Officer or Health Worker in the event of a traumatic or sudden death. The Queensland Health Aboriginal and Torres Strait Islander patient care guideline[34] documents the importance of communication, building rapport and creating a culturally safe environment. It also notes the important role that hospital Indigenous liaison officers play in providing cultural safety and support to patients.

It is also important to note clinical advice received indicates that DRH's handling of Miss Sandy's passing in terms of open disclosure was not culturally appropriate or in line with policies and procedures, as discussed above, which recommend the use of an ILO or AHW. The NWHHS's submission to the OHO advised that as per NWHHS policy, Mr Sandy, as Miss Sandy's next of kin,

[32] Sad news, sorry business – Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying (health.qld.gov.au)
[33] https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD17%2f23849&dbid=AP&chksum=ki92NMPa9thp9f9ZhTQNJg%3d%3d
[34] Aboriginal and Torres Strait Islander Patient Care Guidelines (health.qld.gov.au)

was informed of her death and as next of kin, it was Mr Sandy's decision as to whom he notified of his wife's death. Dr Stevens specifically notes that the request to have Mr Sandy deliver the news of Miss Sandys' death is not the most supportive of cultural needs nor is it a caring and patient centred act. He advised that the optimal solution would have been to identify one point of contact or key family stakeholder with whom to communicate and relay information. Once death had been declared to the next of kin, to offer support for when the next of kin told other family members.

Importantly, Dr Stevens notes that NWHHS completed only basic clinician disclosure following Miss Sandy's death and opined that had the NWHHS executive moved quickly and provided intensive support to the clinicians and DRH, it is highly likely that Mr Sandy would have had the opportunity to understand and ask questions about Miss Sandy's treatment.

7.6.3 Recommendation

Recommendations 3, 4, 10 and 11 as above.

12. Seek, record and review feedback from the Local Shire Council, appropriate community groups and local community members as consumers regarding the Queensland Health guideline 'Sad News, Sorry Business' to:
    a. support the development of a local guideline for caring for Aboriginal and Torres Strait Islander people through death and dying which is culturally safe and Doomadgee- specific
    b. include training in relation to the above guideline as part of the orientation and mandatory training for all DRH staff.

8. Adverse comment submission

Under the *Health Ombudsman Act 2013*, an entity must be given an opportunity to comment on a draft investigation report where that report is going to make adverse comment and the entity is identifiable.

A response was received from Shaun Drummond, Director-General, Queensland Health, on 22 December 2022, on behalf of the Department of Health and NWHHS. All recommendations were supported in principle or in progress, and the OHO have amended some recommendations to acknowledge the work undertaken by NWHHS to date.

9. Conclusion

Miss Sandy's passing remains a deep loss and tragedy for her family and friends as well as the community of Doomadgee who have previously expressed public concern about the provision of health services at DRH. The concerns expressed by the Sandy family are mirrored in recent media reports regarding the deaths of other Indigenous women in Doomadgee of RHD, including Ms Yvette 'Betty' Booth, whose death was the subject of a Queensland Health report. The issues raised in the 'Betty's Story' report are reflected in Mr Sandy's complaint and consequently this report's recommendations are closely aligned with the recommendations from the 'Betty's Story' report.

The OHO would like to acknowledge the work already undertaken by NWHHS in improving the service provided by Doomadgee Rural Hospital since Miss Sandy's passing and their collegiate approach to working with the OHO.

The OHO recognises the unique challenges of healthcare provision in a remote community, particularly where responsibilities for primary health care and emergency care lie with different services and the further complications of COVID-19. However, the tragic loss of Miss Sandy is an

ongoing source of grief for the Doomadgee community, which is deepened with the knowledge that many of the issues identified in the 'Betty's Story' report are replicated in Miss Sandy's care. The OHO is concerned with the apparent lack of progress to date. This report's recommendations are aimed at improving the cultural capability of DRH as well as addressing the communication and coordination of care between services. It is evident that clear and committed action is required to address the issues identified in this report to avoid further preventable deaths and it is expected that DRH will implement the following recommendations as priority actions for the service and the community, and as part of the broader obligations under the NWHHS Health Equity Strategy.

10. Recommendations

It is recommended:

1. DRH continues their progress toward increasing awareness and knowledge of ARF and RHD among all clinical staff who currently, or will, work in locations with a high prevalence of ARF and/or RHD through, for example:
    a. continuing inclusion of an introductory session in the orientation program alerting medical staff, nursing staff and Indigenous health workers to the prevalence of ARF/RHD and what to look for
    b. ensuring clinical staff complete the on-line healthcare professional modules available through RHD Australia as a mandatory part of their clinical orientation
    c. provision of an annual schedule of staff and patient education through the Queensland RHD Registry Office to clinical staff.
2. Provide clinical staff with access to tools that assist them to appropriately detect ARF/RHD by making the RHD Australia 'Guidelines and Diagnosis Calculator' which is in the form of an electronic application (App) for iOS and Android devices available on NWHHS devices, and informing clinical staff. This App provides a text and visual reference for each technical stage of a diagnosis. It is designed to minimise diagnosis error and inconsistency and also filters out cases that aren't rheumatic fever so that a clinician is not over-diagnosing.
3. DRH continues to develop orientation packages and materials that support culturally safe and responsive practice, including exploring the application of these orientation packages for the transient workforce to meet minimum cultural safety standards. This should include:
    a. Engaging with the local Shire Council, Traditional Owners, local community members and appropriate community groups about their experiences to ensure orientation material highlights local community needs, cultural values, beliefs, and practices to assist with strengthening the relationship between Doomadgee Rural Hospital and the Doomadgee community.
    b. Including this orientation as part of mandatory education for completion by all staff during the first month of employment and keeps accurate records of staff completion of this competency.
    c. Seeking and evaluating feedback from community as a measure of cultural safety across service delivery, and working with community to develop and implement improvements to enhance cultural safety.
    d. Including a local Aboriginal community member on staff selection panels for higher grade positions. This may necessitate the establishment of a list of appropriate local Aboriginal community members who would be suitable and willing to be included on staff selection panels.

4. Continue to jointly engage with clinical staff and community leaders to explore what would make local health services more welcoming for patients and Doomadgee a place staff enjoy working and want to stay. This could include conducting interviews with staff as an information gathering exercise to inform a deeper understanding of the organisation and provide insight into why employees initially come to community, why they leave and what might be done differently to retain employees.
5. Continue work already undertaken to improve the use of patient information systems by reviewing:
    a. How staff know to access and use various relevant record systems, for example The Viewer, Communicare and paper charts/notes.
    b. Review the effectiveness of the use of triggers/alerts in the various patient information systems used.
    c. A random sample of recent clinical records and evaluate them against the NWHHS 'Procedure for Clinical Documentation in Patient Records' to develop an appropriate action plan for any identified deficiencies.
6. Continue work already implemented regarding protocols for the conducting of early detection or screening programs, and ongoing management of identified patients, in the NWHHS that include:
    a. A member of screening team visiting the community prior to and after the screening to work with Gidgee Healing and the hospital to educate staff and set up systems for follow up.
    b. Appointing a local coordinator who will have responsibility for ensuring:
        i. there is a clinical debrief held with the screening team to share diagnosis and prioritise actions with:
            A. hospital doctor(s) and nursing staff
            B. Gidgee Healing, or other service as appropriate.

            If staff are not at the debrief, ensure information is shared with those individuals within 1 working day of the debrief.
        ii. copy of the screening results is provided to Gidgee Healing and the HHS
        iii. screening results are entered into Communicare notes within 1 working day of the debrief
        iv. ongoing education provided to those children and families with a confirmed diagnosis
        v. education on RHD is provided to clinical staff (regardless of screening results)
        vi. each person identified with RHD has someone nominated to coordinate their care and a personal management plan with a copy of the management plan located in records held at the hospital and Gidgee Healing
        vii. a care plan (detailing what needs to happen, when and by whom) is compiled in accordance with the National RHD Guidelines and monitored through the morning meetings. Ensure responsibilities are clear:
            A. local medical assessments and reviews are scheduled and completed as required
            B. referrals to specialist services are completed and appointments confirmed within the required timeframe
            C. attendance is facilitated
            D. medication is ordered, commenced and monitored

E. notification to the RHD registry is completed.

c. Seeking and evaluating feedback from the community and staff regarding the programs implemented.

7. Consider how case reviews of patients who frequently present with similar symptoms and/or with complex needs could assist to improve health outcomes.

8. Doomadgee Rural Hospital partners with Gidgee Healing to ensure effective collaboration and coordination regarding each patient's health care journey to ensure integration of care. This will require:

   a. Doomadgee Rural Hospital working proactively with Gidgee Healing to develop a set of working principles for a local service partnership agreement that covers reciprocity (for the benefit of the Aboriginal community), communication, involvement and knowledge. This partnership should be formalised through a local service agreement, formal representation in governance structures and regular meetings that have defined reporting processes ensuring there is clarity and coherence about responsibilities for all aspects of health service delivery.[35] All health services to have full knowledge of principles and priorities for service provision and coordination.

   b. Promotion of improved communication between service providers as part of the local service partnership.[36] This would be achieved through review of any existing communication pathways, identifying and implementing any improvements for information sharing as patients move from one service to another to ensure an individual's engagement with the health system in the community is as seamless as possible. Where consent is given, all health services must have access to current patient information including new diagnosis, investigation and/or health assessment findings, care plans, medications and referrals made.

   c. Creation of a local service agreement (LSA) (in a above) which includes documentation of service delivery responsibilities and expected outcomes for each service and how they work together.

      i. This LSA should include development and consultation with Gidgee Healing and other community health service providers to develop and implement a framework for community consultation. This process must seek input from appropriate community representatives including the local Shire Council and other appropriate community body/bodies, either existing or newly established, to ensure genuine community consultation on local health service design, delivery and evaluation, and community communication strategies. This committee should be tasked with:

         A. developing terms of reference, a meeting schedule (no less than quarterly), recording and distribution of minutes and action items

         B. consultation regarding culturally safe healthcare design, delivery and evaluation, and communication solutions that work best for the community to ensure critical information and alerts are communicated and received in a timely manner[37]

         C. monitor and evaluate progress of agreed outcomes, using data and information to drive change where necessary.

   d. Seek, record and review feedback regarding the LSA from the community.

[35] NSQHS 3.19 Multidisciplinary collaboration.
[36] NSQHS 3.27 Communication to support patient referral and multidisciplinary collaboration.
[37] NSQHS 3.29 Communication of critical information.

e. Review any existing communication pathways between Gidgee Healing and the NWHHS, particularly the structure and format of the morning inter-service meetings to allow:

   i. Representatives of all clinical groups from each local service, the Nurse Navigator Service and any other service regularly involved in the care of patients to be part of any discussion around the care that is needed and/or provided to patients.

   ii. All services in (i) above to have full knowledge of the agreed priorities and which service is coordinating the associated plans of care, or specific actions within those plans.

   iii. All local services to have current patient information including new diagnosis, investigations and/or health assessment findings, care plans, medications and referrals made.

   iv. Promotion of improved communication between service providers. This would be achieved through identifying and implementing mechanisms for information sharing as patients move from one service to another to ensure an individual's engagement with the health system in the community is as seamless as possible. Where consent allows, all services have access to current patient information including new diagnosis, investigation and/or health assessment findings, care plans, medications and referrals made.

9. Continue work already undertaken to establish a consistent approach to applying the national ARF/RHD guidelines, including clarifying and articulating:

   a. Who will coordinate care which includes:

      i. completing and monitoring (including reviews) a personal care plan with the patient and placing a copy of the care plan in records held at the hospital, community health and Gidgee Healing

      ii. scheduling local medical or health assessments and reviews and making sure they occur

      iii. completing referrals to specialist services for review

      iv. monitoring and enacting changes in care made by specialist services

      v. coordinating arrangements for appointments to external services

      vi. monitoring the ordering and administration of medication.

10. Establish open communication channels when a seriously ill patient presents for care by:

   a. continuing to review the use of Indigenous Health Workers and explore the feasibility of an expanded role where they provide a link between clinical staff and family members when a seriously ill patient is being treated at the hospital

   b. exploring with the Doomadgee community how individuals and families may be supported when they are receiving treatment at the hospital for serious illness.

11. Review the accessibility of DRH, with particular focus on accessibility after hours, by:

   a. seeking, recording and reviewing feedback from the local Shire Council, appropriate community groups and local community members as consumers regarding the accessibility of DRH, including what would make it more welcoming and culturally safe

   b. reviewing the security measures in place at DRH

   c. engaging with the local Shire Council and appropriate community groups to explain the requirement for security measures for staff and patient safety and improve awareness of accessibility of DRH despite these security measures.

12. Seek, record and review feedback from the Local Shire Council, appropriate community groups and local community members as consumers regarding the Queensland Health guideline 'Sad News, Sorry Business' to:

    a. support the development of a local guideline for caring for Aboriginal and Torres Strait Islander people through death and dying which is culturally safe and Doomadgee- specific

    b. include training in relation to the above guideline as part of the orientation and mandatory training for all DRH staff.

Dr Lynne Coulson Barr OAM

Health Ombudsman

Date: 28 April 2023

11. Appendix 1—Miss Sandy's timeline (detailed key events)

Table 1

Source	Date	Notes
DRH	1988	November - First entry in Doomadgee Rural Hospital records. Presented to hospital with vomiting - impression of viral gastro. Noted that rheumatic fever diagnosed in Tennant Creek. December – noted to be visiting Tenant Creek for undecided period.
DRH	1990	January – outpatient medical review, plan for cardiology review in 6 months February – presented with vomiting, headache March – noted last IMI penicillin was in August 1989 April – presented with barking cough, sore ears and throat, fever June – presented with coughing, runny nose, breathlessness July – presented with cough and rhinorrhea August – presented with persistent cough (weeks) September – in Tennant Creek October – presented with vomiting. 30/10/1990 – monthly bicillin due and informed patient was at Dry Creek December – ECG + CXR taken (routine check)
DRH	1991	February – Outpatient Cardiology review. CXR and ECG normal. "No evidence of heart disease." R/V 1 year
DRH	1992	February – presented with aching ears (25th) and coughing (28th) November – Outpatient paediatric review December – presented with choreiform movements
DRH	1996	June – presented with sore throat and pain in neck (7th) and pain under right breast, sore throat, cough and swollen red tonsils (27th) November – presented with 2 burst blisters on left foot
DRH	1997	March – seen in Paediatric Cardiology clinic at MIBH September – presented with sore throat, large red and inflamed tonsils
DRH	1998	June – Outpatient paediatric notes – notes "Issue of significance: Problem with getting to hospital and also Miss Sandy's fear of needles + hospitals." November – Paediatric cardiology review at MIBH notes "…mother still states she has a problem getting Miss Sandy up to the hospital to have her injections and that maybe an arrangement for the Health Care Worker to pick Miss Sandy up on the designated day should be entertained."
DRH	2000	May – presented feeling generally unwell + headache. Postnatal (delivered Dec 99) Right lower molar at back rotten. Large cavity left back molar June – presented with chest pain, noted "has not had bicillin injection since 24/5/00."
DRH	2001	February – brought in by mother who is concerned that she has not seen cardiologist for 2 years. March – presented feeling unwell, cough, pain in lower and side of abdomen (10th) and retrosternal pain (26th) where it was noted Bicillin was missed last month and this month. Unable to give Bicillin as applicator had disappeared

Source	Date	Notes
		– encouraged to return next week. April – presented with boil on back, given Bicillin and requested pregnancy test September – presented with pain in lower back and dental caries left side (25th) and continuing back pain and sore ear (27th) October – noted to be booked for repeat ultrasound but “unable to go no money no clean clothes. Explained the importance of U/S attendance but still the responsibility is hers to go or not; still refused to go; even so that she will be “picked up and delivered to destination”. November – 28+4 gestation
DRH	2002	April – presented with sores on left foot, problems walking (24th) and sore throat, black outs and falling with right foot sepsis (27th). It was also noted “no alcohol” on 27th. October – review by visiting cardiologist (1st) and left foot wound (26th)
DRH	2002	April – presented with sores on left foot, problems walking (24th) and sore throat, black outs and falling with right foot sepsis (27th). It was also noted “no alcohol” on 27th. October – review by visiting cardiologist (1st) and left foot wound (26th)
DRH	2002	April – presented with sores on left foot, problems walking (24th) and sore throat, black outs and falling with right foot sepsis (27th). It was also noted “no alcohol” on 27th. October – review by visiting cardiologist (1st) and left foot wound (26th)
DRH	2003	March – presented feeling unwell. Right sided pain and sore throat. Boils noted. July – brought in by friend who witnessed Miss Sandy collapse. 3 months pregnant October – presented with back and lower abdominal pain
MIBH	2003	October – Consultant SC King. Antenatal visit. ‘Nil’ noted for alcohol before and after pregnancy.
DRH	2005	March – presented with left sided toothache lower molar. Noted: “Denies drinking ETOH tonight.” April – “Presented on advice of cardiologist for bloods. Noted advice in outpt (outpatient) notes...” June – Notes say recalled for pathology (7th). 8th – no show and placed on 9th recall list. 10th – no show. 13th – placed on recall list for pathology collection. 14th – removed from recall list. November – brought in by QAS after collapsing. Low BP. Pregnant.
DRH	2006	March – “Phone discussion had with Leonie Moore (Mt Isa DON) re this pt. There will be no paediatrician in Mt Isa until further notice. Due to this pt having a high risk pregnancy she is to go to Townsville Hosp to deliver rather than MIBH. If Dr Bila has any queries he can call Dr King. Attempt made to phone pt to ensure if she was still in Doomadgee but nobody answering. Pt put on recall list for Monday to have changes explained to her + organise travel.” May – presented for RHF check-up. ECG recorded (5th). Presented with toothache on 23rd and 30th.

Source	Date	Notes
DRH	2007	April – TPCH Dept of Cardiology outreach clinic report on echocardiogram. November – presented to antenatal clinic as pregnant
DRH	2008	May – presented and transferred via RFDS for labour and delivery of baby at MIBH June – recalled to see doctor regarding cardiovascular disease antibiotics August – 2 month post partum check. September – presents with toothache (9th) and sore ear (10th) November – Specialist outreach cardiology Doomadgee clinic
DRH	2009	March – Doomadgee Specialist Outreach Clinic - Plan to arrange surgical opinion and transoesophageal echo at TPCH. April – presented with toothache "Pt is currently awaiting cardiac r/v + dental clearance; pt ?needs urgent dental referral pre-surgery; pt to return mane for MO r/v." May - To Dr Christian Hamilton-Craig, Cardiologist, PCH "In view of her residence in Doomadgee and multiple other family members having had rheumatic heart disease, I think that in the context of this young lady, it's probably reasonable to consider mechanical MVR as I think she's reasonably sensible and will adhere to Warfarin which I discussed extensively with her today." June – "Phone call from cardiac hospital re mitral valve surgery. Poss time: End of august. Pt need dental clearance ASAP. On recall 17/6/09 for MO R/V for ? Mt Isa dental review ? extraction." July – Specialist outreach cardiology Doomadgee clinic August – "Cardiac hospital wanting Pt dental check ASAP." Recall notes on 5, 6, 7, 10, 11, 12, 13th August 2009. 13th – presented for review. Dentist has taken tooth out. October – The Prince Charles Hospital Heart Operation Report "An extensive pre-operative discussion was undertaken and she elected to have a mechanical mitral valve replacement, being well aware of the risks associated with Warfarin into the longer term." 27th October – Presenting for routine INR and backache. Testing conducted 3 times with same results, to return tomorrow for INR venous to lab. Returned 28/10/2009 for venous bloods for warfarin monitoring. 2 silk sutures removed. 30th October – INR drawn – out of range of machine. MO aware. Call received from Mt Isa pathology. INR is 9.0. Dr Bila informed. No further orders. November – 2nd – INR 4.8. One blood test not performed as "citrate tube overfilled". 17th – Specialist outreach cardiology Doomadgee clinic "She has been having her Warfarin checked regularly and is recovering nicely from the surgery." 27th – presents for INR – sent to lab as no istat cartridges available.
DRH	2010	February – "Adele presented for chronic meds ? not managing meds." April – Doomadgee specialist outreach clinic. "Since her surgery she tells me that she has been feeling well and has been compliant with her Warfarin." July – presented for INR check and collection of medication. "She hasn't had warfarin for 7/12 last collection 10/2/10. Her excuse is that it's a bit hard for her to get in. INR 1.0 Not a surprise." October – presented for INR. Noted hasn't taken medication since July. "She smokes about 7-10 cigarettes a day and we had a discussion regarding this. She does not consume any alcohol."

Source	Date	Notes
		July – referral to ICOP for echocardiogram August – noted hasn't taken warfarin in over 3 months due to moving house and too busy. September – Doomadgee cardiology outreach clinic. Indigenous cardiac outreach program: "Pt has said she has not had her Bicillin tablets since last year as she is met with barriers everytime she presents to the hospital for the script re emergencies requiring her to wait."
DRH	2016	February – Indigenous cardiac outreach program review
DRH	2017	23rd May – brought in by QAS with "Altered mental state/neurological symptoms – weakness" "Adult female presents via QAS after suffering an apparent CVA while actively driving a car…On entering the A&E she has visible left sided asymmetrical facial droop and left sided weakness. The assumption was an active CVA and her partner admitted she has been non-compliant with warfarin and LA Bicillin for > one year." Referral letter to MIBH: "Non-compliant!!!!! The patient has not taken the medication listed below in OVER 12 months!!!!!!" Transported by RFDS to MIBH.
MIBH	2017	Discharge summary (admission date 24/05/2017) Other active problems and previous medical history note "ETOH abuse". "Patient non compliant with Warfarin which will be the best preventative for further TIA and stroke – explained to pt the importance of this and referred ALO team to help assist and discuss compliance in the community." Recommendations to GP "Please recommence Warfarin therapy and impress upon pt importance of taking Warfarin and not drinking alcohol with this. I have also rung Dr Hamilton to explain the plan and he will assist with re-warfarinisation should the patient present."
DRH	11/10/17	October – admitted with diagnosis of CVA (11th), discharged at own risk (12th).
DRH	2018	February – TPCH, MNHHS – Dept of Cardiology, Doomadgee cardiology outreach clinic "she is taking her medications intermittently. The last time she took her tablets was two weeks ago. I note that in May last year she had a TIA in the same setting. I tried to educate her again today…Given that she has poor compliance with her medications, I would be keen to continue only Warfarin…" "We have to think about a mechanism of how we make sure she is compliant with her treatment." May - TPCH, MNHHS – Dept of Cardiology Doomadgee cardiology outreach clinic. "we have had issues with her Warfarin compliance…she reports being compliant with Warfarin and getting her INRs checked every one to two weeks at the hospital…INRs have mostly been supratherapeutic over the last two months." June - Inadequately identified specimen accepted for testing "specimen analysed, critical INR/PT". July – Doomadgee cardiology outreach clinic. Notes she has run out of warfarin and penicillin several days ago and records detail "smoker" and "alcohol" in specialist notes. October - Doomadgee cardiology outreach clinic

Source	Date	Notes
		"Unfortunately, her non-adherence with her Warfarin has been the recurrent theme of her management over the past few years. Fortunately, she has not had a major event, in particular mechanical valve thrombosis, over the past few years despite her non-adherence."
DRH	2019 (Feb to July)	February – Doomadgee cardiology outreach clinic "Unfortunately, compliance remains the issue for her. She is unable to recall when the last time she had Warfarin therapy was. She doesn't have any warfarin at home at the moment. The most recent INR that I can see in the chart was done about two weeks ago and was 1…otherwise she has no symptoms of heart failure and no chest pain." "I reemphasised the need to be compliant with Warfarin therapy as for her it can be fatal. So far she is lucky that she hasn't had any major problems with her valve." May – Gidgee Healing notes she has not had any medication for many months and Miss Sandy happy for GH to take over care from DRH. July – GH notes Miss Sandy has not been taking her medications. Doomadgee cardiology outreach clinic
GH	2019	7th November – presented to GH for INR (8).
QAS	2019	12th November – QAS – eARF Received 09:34, on scene 09:43, at patient N/A, depart scene 09:59, hospital notified 09:58, at destination 09:59 "36 female with 9/10 lower abdominal pain…pt saw own dr and is waiting for results…Pt refused analgesic. Pt tachycardia, all other VSS within normal parameters." Handwritten note "recalled by GH refused to come in"
DRH	2019 (Nov)	12th November – Medication chart shows medications administered to Miss Sandy including Buscopan, Paracetamol, Lactulose and Glycerol suppository. 15th November – notes reflect "seen here on 12/11 with abdo distension and poorly localised pain…asked to return daily for INR, failed to present despite several reminders (husband also works for GH!)". Transferred by RFDS to Mt Isa.
MIBH	2019	16th November – noted conflicting history from doctor notes and patient. "Patient sure that she visited GP on 8/11/19. INR was 8. Stopped warfarin 9/11/19. Visited GP for repeat INR on 11/11/19, unable to recall results. Stopped warfarin 11/11/19 till date. Notes from Doomadgee & handover from Dr Orda as he was in Doomadgee: ▪ presented to Doomadgee hospital on 11/11/19 due to abdo pain, INR>8 ▪ was told to re-present daily for review and repeat INR ▪ however patient did not attend till 15/11/19 when pain got worse ▪ reviewed by Dr Orda in Doomadgee, patient was 'white' Hb was 35 on iSTAT, given 1L fluid bolus, immediately started to have SOB + rales on auscultation. IV frusemide given which resolve issue after diuresis. INR unrecordable in Doomadgee." 23rd November – Discharge summary – ""Decided to discharge patient with clexane instead of warfarin as she would need bridging if she would proceed with surgery in Dec." Recommendations to GP:

Source	Date	Notes
		"It will be easier for her if she is on clexane for 2/52 rather than asking her to start the bridging therapy herself. Please call Miss Sandy for review and ensure compliance of clexane."
DRH	2020	January - Specialist outpatient referral to Dr Umayal Lakshman (medical) "well known RHD patient that was lost to follow up with medical and cardiac team. Dr Kalum has discussed this patient with Dr Uma. For review in outreach clinic." February - Medical outreach – Dr Lakshman/Schmidt/Sabu. Background recorded of "ETOH, non compliance with meds." Noted not to drink alcohol currently. 27th May – 8pm admitted to ward with atrial flutter, case discussed with Mt Isa and plan for admission overnight on cardiac monitoring. 29th May – ward round with MO noted "ok overnight. This morning c/o some epigastric discomfort + nausea. NO for few days." Discharged summary notes: Admitted 27/5 19:54, dx 29/5 11:00 "c/o subjective SOB a few hours, palpitations. No chest pain/cough/URTI" "Poor warfarin compliance, chronic issue" "o/e GC good. Not distressed. P=140 irreg BP=95/65 Sats=92%RA. Afebrile" "ECG: Aflutter with 2:1 block @ 140bpm. Trop=0.15. Chem 8 unremarkable" "Reverted to sinus rhythm after these measures, and SOB resolved. Likely Type 2 trop leak – d/w Dr Kallam, Mt Isa Med Consultant – agrees." Recommendations to GP: "F/U re Warfarin management. Does seem rather sensitive to Warfarin & note previous severe bleed from high INR." 30th May – brought in by QAS with "abdo pain, SOB, and rapid AF. QAS unable to get radial pulse or B/P". Noted "Discharged from DMG Hospital after brief episode of AF, which revered quickly after one dose of IV MgSO4. Was inpatient for 2 further days to re-commence on Warfarin. On discharge 36hrs ago, INR=3.9. Given NO further warfarin since then." "Possible Intra-abdominal bleed, given abdo pain & PMH[38] & INR ?high; Possible cold Sepsis; Possible embolic episode with Bowel Ischaemia? …d/w ED SMO in Mt Isa – agress [sic] with current regime and accepted for T/F. d/w RSQ[39] – accpted [sic] for retrieval." "a few seconds later [at 1715] after telling the patient what RFDS had said, the sclera of both eyes, went red patient became unresponsive, CPR started by RN Edward" "1815pm – cpr stopped, Patient partner brought in and MO spoke to partner" June – Cause of death certificate. July – Coroner certificate of analysis – forensic toxicology. NWHHS clinical review. November – Coroner autopsy certificate.

[38] Past medical history
[39] Retrieval Services Queensland