

Investigation report

Quality of health services provided at Cairns Hospital

March 2018



Office of the
**HEALTH
OMBUDSMAN**

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Background

The incident

On 11 April 2015, Mr Arkadiusz (Arthur) Tumanis presented to the Cairns Hospital emergency department (ED) with severe abdominal pain, nausea and vomiting; he had been unwell since the previous day.

Arthur was 39 years old and had been living with his father in Cairns for approximately two months since relocating from Adelaide. He had been diagnosed with a mental illness at the age of 24 and had a history of recreational drug use.¹

Arthur was seen in the ED and had a number of tests performed; his physical examination and chest x-ray appeared normal with blood tests indicating his white cell count was elevated. He was discharged with a script for panadeine forte² and a letter for follow-up with his general practitioner (GP).

Early the following morning Arthur's father called an ambulance due to Arthur's ongoing abdominal pain and vomiting. He was transported by ambulance to the ED arriving at 5.10 am, and was assessed at 8.10 am. Arthur was treated with intravenous fluids, antiemetic and analgesia medication, it was noted there was 'nil organic cause of pain identified' and it was planned to discharge Arthur with an outpatient referral for a mental health assessment and follow-up with his GP.³

Prior to discharge, Arthur became agitated and disruptive and was relocated to the designated mental health assessment area within the ED. A summary of Arthur's medical history was sought from the Royal Adelaide Hospital which provided information on two recent presentations to that hospital. This included a presentation to the ED in February 2015 with what was described as an acute psychotic episode and an admission in September 2014 due to a suspected polysubstance overdose. This medical history recorded intermittent abdominal pain as an issue during admission, noting it was likely secondary to tetrahydrocannabinol⁴ abuse.

On the afternoon of 12 April 2015, Arthur was admitted to the Cairns Hospital Mental Health Unit (MHU) under an Involuntary Treatment Order (ITO). The purpose of the admission was for a 'Brief admission for control of symptoms and to help father develop a community management approach to his ongoing symptoms'.⁵

During the two days Arthur spent in the MHU, he complained repeatedly to his father and staff of severe pain. Following his admission to the MHU, he was reviewed on 13 April 2015, and a plan was recorded to transfer Arthur to the low dependency unit (LDU) within the MHU when a bed became available. He

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- ¹ Report prepared by the Forensic Medical Officer, Dr Les Griffiths, for the Coroner's Court of Queensland (formerly the Office of the State Coroner), provided to the office by the northern coroner on 26 February 2016.
 - ² Medication used to relieve moderate to severe pain and fever; contains paracetamol and codeine.
 - ³ Progress Notes Emergency, 12 April 2015, signed 1.19 pm.
 - ⁴ Tetrahydrocannabinol is the chemical responsible for most of marijuana's psychological effects.
 - ⁵ Progress Notes Inpatient, 12 April 2015, signed 6.09 pm.

was also seen on two occasions on 14 April 2015 in response to his agitated state and requests for pain medication. The recorded plan in response to both of these reviews was to 'use distraction techniques to deescalate patient'.

Late on the evening of 14 April 2015, Arthur was found unresponsive and pulseless in a chair near the nurses' station. Medical staff were unsuccessful in attempts to resuscitate Arthur; his death was reported to the Coroner's Court of Queensland (formerly the Office of the State Coroner) for investigation as a reportable death under the *Coroners Act 2003*.⁶

Arthur's death was found to be a result of peritonitis due to a perforated duodenal ulcer.⁷

Office of the Health Ombudsman's involvement

The Office of the Health Ombudsman (the office) received a complaint from Arthur's father (the complainant) on 5 May 2015, concerning the care his son received while a patient at the Cairns Hospital from 11 April 2015 until his death on 14 April 2015.

The office assessed the complaint and subsequently commenced an investigation on 15 May 2015. In addition, Arthur's mother also contacted the office during the investigation and, in consultation with the complainant, has been included in all correspondence with the office.

The health service provider

Facility overview

The Cairns and Hinterland Hospital and Health Service (CHHHS) is a statutory body⁸ independently and locally controlled by a hospital and health board. The CHHHS board was newly appointed on 16 May 2017, following the resignation of the previous board in September 2016.

The Cairns Hospital is the largest major hospital in Far North Queensland with 531 inpatient beds and a 52 bed ED.⁹ The hospital provides specialist care services and is the major referral centre for Far North Queensland, with the nearest tertiary hospital located 350kms away in Townsville.¹⁰

The Cairns Hospital Mental Health Unit

The Cairns Hospital MHU is located in the lower area of the general hospital. The unit has undergone a number of operational and physical changes since Arthur's death and is currently configured as:

⁶ As the patient was an inpatient in an authorised mental health service his death was deemed to be both a 'health care related death' and 'death in care', and therefore a 'reportable death' under section 8(3) of the *Coroners Act 2003*.

⁷ Autopsy Report of Mr Arthur Tumanis, conducted by M R Stewart, 8 May 2015

⁸ As defined in the *Hospital and Health Boards Act 2011* (Qld).

⁹ Patient information directory, Cairns Hospital 2017–18.

¹⁰ Cairns and Hinterland Hospital and Health Service, Annual Report 2016–17.

- Low Dependency Unit (LDU)—38 beds designed as two units, with LDU 1 receiving patients of a higher acuity
- Psychiatric Intensive Care Unit (PICU)—eight beds with two seclusion rooms.

In 2015, the PICU was described as:

a specialised unit providing close observation, assessment and treatment of consumers experiencing an acute exacerbation of their mental illness posing a serious risk to self or others who are detained under the *Mental Health Act 2000* and whose level of disturbance requires containment and more intensive nursing care.¹¹

At the time of Arthur's admission, adult mental health services operated as an 'integrated' model of care at the CHHHS, requiring psychiatrists and registrars to work across both inpatient and community programmes. However this model resulted in either or both of these practitioner roles being absent from the MHU on some days. A 'de-integrated' model of service now operates at the hospital with multidisciplinary teams responsible for assessing and treating patients within the inpatient setting only.¹²

A recent review commissioned by the CHHHS of the Mental Health and Alcohol Tobacco and Other Drugs Service (ATODS), identified an integrated model of service as the preferred approach and has made recommendations to facilitate moves towards a partially integrated model of care while a number of other challenges are addressed. The report also identified significant problems with the MHU's inpatient facility describing it as 'not fit for purpose' and recommended its replacement with a new purpose-built mental health facility.¹³

A \$70 million project to develop a new mental health unit was announced in the 2016–17 Queensland state budget and plans for the replacement of mental health infrastructure in Cairns to improve both inpatient and community mental health facilities will commence during 2017–18.¹⁴

The office's investigation

Investigation scope

The initial scope of the investigation was to determine whether the health care and treatment provided by CHHHS to Arthur contributed to his death.

Concurrent with the office's investigation, the then northern coroner, Mr Kevin Priestly, was also investigating Arthur's death. During the office's investigation, the coroner released information—obtained

¹¹ CHHHS Procedure – Psychiatric Intensive Care Unit, date of effect 9 October 2014.

¹² CHHHS, Health Service Review of the Mental Health and Alcohol Tobacco and Other Drugs Service, January 2017.

¹³ CHHHS, Health Service Review of the Mental Health and Alcohol Tobacco and Other Drugs Service, January 2017.

¹⁴ Cairns and Hinterland Hospital and Health Service, Annual Report 2016–17.

pursuant to the *Coroners Act 2003*—to the office and provided regular updates on the progress of the coronial investigation.

In May 2016, the office redefined the scope of the investigation to avoid duplication and potential cross-contamination of evidence with the coroner's investigation. In consultation with the coroner, the scope of the investigation was condensed to focus on the remedial measures identified in the root cause analysis (RCA) conducted by CHHHS into the incident.

The office determined that the RCA report prepared by CHHHS represented a thorough and comprehensive analysis of the health care and treatment Arthur received from the time of his presentation to the ED on 12 April 2015, up until his death on 14 April 2015. On this basis, the office was satisfied the report's findings and recommendations for improvement could be relied upon to address the issues identified in the RCA and that, if implemented, would prevent a similar event from occurring.

From this point, the investigation focused on the implementation status of the RCA report's ten recommendations and five 'lessons learnt'¹⁵ recommendations. It also considered any additional system or process issues that have arisen as a result of Arthur's death.

Inquiries by the office

During the investigation the office requested, reviewed and analysed a substantial amount of information; this was used to determine the implementation status of each recommendation and the adequacy of the improvement actions undertaken by CHHHS to address issues identified in the RCA report.

This was conducted in conjunction with a three day site visit in August 2017 to the Cairns Hospital to gain a broader understanding of the CHHHS governance structure, health service systems and processes, and the quality of the improvement activities that had been implemented or were in progress, in response to the RCA recommendations.

Staff from the office also met with the complainant following the visit to the Cairns Hospital to provide a detailed update on the status of the investigation.

In addition and separate to this investigation, the office referred a number of registered practitioners to the Australian Health Practitioner Regulation Agency (AHPRA) for assessment by AHPRA to determine whether any further action should be taken against them.

RCA recommendation progress

An RCA is an internationally recognised approach used to analyse serious clinical incidents in the provision of healthcare that result in permanent harm or unexpected death. The purpose of an RCA is to

¹⁵ A 'lesson learnt' recommendation is an additional corrective action identified by the RCA team in response to an issue that may not have directly contributed to the patient's adverse outcome, but represents an opportunity for service improvement.

improve patient safety by identifying weaknesses in healthcare systems and processes, and make recommendations to prevent an occurrence of a similar event.¹⁶

An RCA must be conducted in accordance with legislated provisions and guiding principles, which also provide certain privacy protections and disclosure restrictions.¹⁷ This legislated approach to the review of serious clinical incidents does not seek to determine liability or apportion blame to individuals. Consequently, this investigation report is unable to reference information contained in the RCA report or its recommendations in any detail; this report is only able to outline the steps taken by the office to determine the implementation status of the RCA recommendations.

During the investigation, the office received two progress updates from CHHHS on the implementation progress of the recommendations, which included information and evidence to support the status assigned to each recommendation by CHHHS. At the time of the second update report,¹⁸ the CHHHS reported that all recommendations had been 'implemented', with the exception of one recommendation which was due for completion by the end of June 2017.

The office conducted a detailed review of each of the progress updates and prepared a recommendation implementation status report,¹⁹ which included:

- a brief summary of key information submitted in each of the progress updates
- the implementation status assigned by CHHHS to each recommendation
- a brief analysis of the information provided in each progress update and its effectiveness in demonstrating the status assigned by CHHHS
- the implementation status assigned by the office to each recommendation.

The office provided CHHHS with a copy of this report on 11 August 2017, advising there was insufficient evidence to support the 'implemented' status²⁰ CHHHS had assigned to four of the recommendations. See [appendix 1](#) for an explanation of implementation definitions.

Site visit to Cairns Hospital

Subsequently, the office requested an opportunity to visit the Cairns Hospital and meet with CHHHS representatives responsible for the oversight, management and implementation of the RCA recommendations. Office staff sought to discuss relevant improvement actions and activities that had been implemented, and review a sample of implemented initiatives to assess their success in achieving their intended outcome.

¹⁶ Department of Health, Review of Root Cause Analysis Legislation, 2013, Queensland Government.

¹⁷ An RCA report is protected by disclosure restrictions under the *Hospital and Health Boards Act 2011* (Qld) and cannot be published by this office.

¹⁸ Prepared by CHHHS for the northern coroner, 4 May 2017.

¹⁹ This report details the progress of the RCA recommendations; based on legal advice the office is unable to publish the content of this report.

²⁰ The office considered CHHHS's 'implemented' status to be the equivalent of 'fully implemented'.

A three-day site visit was arranged, commencing 28 August 2017. Two senior staff from the office met with members of the CHHHS's executive team, clinicians from the ED, MHU and ATODS and representatives from the CHHHS's legal division.

The site visit provided the opportunity to discuss:

- the CHHHS governance arrangements for the oversight and evaluation of recommendations arising from investigations and reviews
- the four recommendations assigned a 'partially implemented' status by the office
- the one recommendation CHHHS advised was due to be implemented by June 2017
- a sample of 'fully implemented' recommendations to determine the effectiveness of the improvement actions and activities in addressing the intent of the recommendations.

The visit was an excellent opportunity to directly discuss the changes, challenges, initiatives and plans for ongoing improvements within the MHU and broader CHHHS. During the visit additional information was provided to either demonstrate the 'fully implemented' status of a recommendation or illustrate the review and evaluation strategies in place.

Meeting with the complainant

Following the site visit, the office staff then met with the complainant on 31 August 2017. The meeting provided a constructive opportunity to share information in person and discuss elements of the incident and the investigation in detail. At the meeting:

- the complainant shared his perspective and recollections of his son's hospital admission
- office staff provided feedback to the complainant on the observations and outcomes from the three day site visit at Cairns Hospital
- office staff provided an explanation to the complainant of the remaining steps in the investigation and the anticipated timeframes for completion.

During the meeting the complainant raised a number of issues, including:

- that the initial open disclosure²¹ meeting with the CHHHS following Arthur's death was unhelpful and distressing
- that individual practitioners have not been held to account for the treatment provided to Arthur
- that the northern coroner had indicated that, based on his preliminary findings, it was unlikely there would be an inquest held into Arthur's death.

In response to these issues, the office made a request on behalf of the complainant to the CHHHS to arrange for a further open disclosure meeting. The complainant advised this meeting took place on 2

²¹ Open disclosure describes an ongoing process of open discussion between an organisation and the patient, and/or their family and carers, about adverse events that resulted in harm to the patient while receiving health care.

November 2017 and explained that he felt it was conducted with compassion and that there was a genuine attempt to satisfy his questions as much as possible.

The office also contacted the northern coroner to discuss the status of the coroner's investigation. Subsequently, the office determined it appropriate to initiate a review—separate to this investigation—into the health care provided to Arthur at or around 2 pm on 14 April 2015. This review was to determine if the conduct and/or performance of any other individual practitioners involved required investigation; as a result, the office referred additional practitioners to AHPRA.

Issues identified

This investigation focused on the RCA report commissioned by the CHHHS and has sought to determine if the RCA recommendations were adequately implemented, thereby preventing a similar incident from occurring. The investigation also sought to identify and consider any system or process issues that had not been identified or addressed in the RCA report.

The investigation identified a number of issues related to the CHHHS's governance systems and the impact of inadequate systems on patient health outcomes—in particular patients with complex care needs.

Adequacy of RCA recommendation implementation

To demonstrate the implementation of the RCA recommendations, the CHHHS provided the office with evidence at the Cairns Hospital site visit and supplied two implementation progress reports pursuant to the office's information requests. The office conducted a thorough review of this information and evidence to assess the effectiveness of the CHHHS's actions and activities.

Health Ombudsman's findings

Through information provided during the site visit, the office assessed all recommendations arising from the RCA as 'fully implemented' at CHHHS.

My office has determined that, through the implementation of the recommendations, the CHHHS has introduced effective system and process improvements that will prevent a similar incident from occurring at the Cairns Hospital in future.

Dual diagnosis

During the office's Cairns Hospital site visit, discussions with clinical staff repeatedly raised the complexities and challenges associated with the provision of quality, evidence-based care and treatment for patients with a dual diagnosis. The complainant also raised concerns of staff bias against his son due to his history of drug use and his mental health history.

Dual diagnosis covers a wide range of presentations and conditions and is defined by Queensland Health²² as the co-occurrence of two or more problems or disorders, one of which is a mental health problem and at least one of which relates to the use of alcohol and other drugs; a person with a dual diagnosis is someone who has a mental health problem and a substance use problem.²³

Compared to patients with single morbidities, patients with dual diagnoses are reported to experience poorer medical, psychological, social and familial outcomes.²⁴ The scale of dual diagnosis in Australia varies, with estimates indicating that:

- 64 per cent of psychiatric inpatients may have a current or previous drug use problem
- 75 per cent of people with alcohol and substance use problems may have a mental illness
- 90 per cent of males with schizophrenia may have a substance use problem.²⁵

There is increasing recognition of the impact an individual's mental health can have on their physical health and there is now greater emphasis placed on the provision of holistic care for people with a mental illness when presenting in the ED. The physical examination of an individual in the ED seeks to reasonably exclude organic disease as either:

- a cause for the presentation, or
- a clinical issue requiring acute management.

A major risk in mental health emergency presentations is misdiagnosis or missing a physical cause for the presenting problem. This can be complicated if a patient's mental illness prevents effective communication of physical symptoms or if the physical illness is a stressor that could exacerbate a person's mental illness.²⁶ Additionally, a health care provider's lack of professional knowledge about dual diagnosis can result in the patient being seen as difficult and unresponsive to treatment.²⁷

Queensland Health's dual diagnosis policy describes people with dual diagnosis as the core business of mental health and alcohol and other drug services and defines the principles informing and guiding the delivery of treatment. This includes providing a recovery based integrated care approach and developing effective collaborative partnerships. It also outlines the responsibilities of services when treating patients,

²² Queensland Health is a department of the Queensland Government and operates the state's public health and hospital system.

²³ Queensland Health Policy, Service delivery for people with dual diagnosis, Queensland Health, September 2008.

²⁴ McCallum S., Mikocka-Walus A., Turnbull D., Andres J. (2015). Continuity of care in dual diagnosis treatment: Definitions, applications and implications, *Journal of Dual diagnosis*, p. 218.

²⁵ Substance abuse and mental illness – dual diagnosis, downloaded on 16 November 2017 from – www.betterhealth.vi.gov.au/health/conditionsandtreatments/substance-abuse-and-mental-illness-dual-diagnosis.

²⁶ Mental health for Emergency Departments – A Reference Guide, NSW Government Health, 2015.

²⁷ Substance abuse and mental illness – dual diagnosis, downloaded on 16 November 2017 from – www.betterhealth.vi.gov.au/health/conditionsandtreatments/substance-abuse-and-mental-illness-dual-diagnosis.

which includes providing interventions that are matched to a person's presentation and treating people with a professional, non-judgemental approach.²⁸

The effective management of mental health disorders and substance use disorders is challenging and the integration of treatment can be difficult.²⁹ This can be further complicated when people receiving inpatient treatment in a psychiatric setting also experience an acute physiological deterioration, adding another layer of complexity to be recognised and responded to. This occurs relatively infrequently within the psychiatric setting, however if and when it does occur, services must provide a timely and appropriate treatment response.³⁰

Arthur's physiological deterioration during his admission to the MHU highlights challenges associated with the provision of quality integrated care in a single setting when treating someone with complex health issues.

Arthur's medical records and progress notes clearly recorded and referenced his dual diagnosis of schizophrenia and polysubstance use, and included a corroborative history from the Royal Adelaide Hospital. At the time of his physical examination in the ED on 12 April 2015, no organic cause for his pain was identified. However, on assessment in the PICU that evening, the medical notes flagged the possibility that Arthur required further diagnostic clarification, explaining he was 'fixated on obtaining drugs however at the same time there are elements that suggest underlying this he may be genuinely deteriorating'.³¹

During the time Arthur spent in the MHU's PICU and LDU, the progress notes made by nursing and medical staff refer to his repeated and continuous requests for pain medication and his anxious and aggressive behaviour; he was recorded at times to be histrionic, crawling, shouting, panting and hyperventilating.

At 2.10 pm on the afternoon of 14 April 2015, Arthur's vital observations were recorded as: pulse 154 beats per minute, respirations 24, blood pressure 130/94 and oxygen saturation 98 per cent. It was noted he had 'coughed up blood stained sputum and later vomited'; '? Opioid withdrawals' was recorded in the notes. Arthur was given a further PRN of CPZ³² at 2.30 pm with little or no effect. Arthur continued to complain of pain and it was recorded he 'deliberately banged head on bathroom wall x 1 in frustration'. Following this, at 3.25 pm he was taken to the 'time out room' 'to reduce anxiety'.³³

At 4.47 pm he was reviewed and the progress notes state he was 'agitated and sweating and demanding medication for his pain', vital observations were 'stable' and the clinical impression was 'drug seeking

²⁸ Queensland Health Policy, Service delivery for people with dual diagnosis, Queensland Health, September 2008.

²⁹ Substance abuse and mental illness – dual diagnosis, downloaded on 16 November 2017 from – www.betterhealth.vi.gov.au/health/conditionsandtreatments/substance-abuse-and-mental-illness-dual-diagnosis.

³⁰ Mental health fact sheet 1: An overview of recognition and response systems.

³¹ Progress Notes Inpatient, 12 April 2015, signed 6.09 pm.

³² PRN is from the Latin *pro re nata* meaning 'when necessary'. CPZ refers to chlorpromazine, an anti-psychotic medication used to treat psychotic disorders, also used to treat nausea and vomiting.

³³ Progress Notes Inpatient, 14 April 2015, signed 4.31 pm.

and medically clear'. Later that evening, it was recorded in the progress notes that a range of blood tests had been ordered, however Arthur was not seen at the time.

The CHHHS's 2011 *Work Instruction—Medical Emergencies*³⁴ provided specific clinical criteria for staff to reference and understand when an emergency call must be made to the medical emergency team (MET). According to the work instruction's criteria, observations recorded by nursing staff at 2.10 pm for Arthur's pulse and blood pressure both were at a level above the threshold criteria requiring a MET call.³⁵ Despite multiple indicators suggesting Arthur's condition was deteriorating, staff failed to initiate a MET call.

Arthur spent the afternoon and evening moving in and out of the time out room until this ceased at 8.30 pm and he moved to a chair near the nurse's station. Arthur remained in the chair until a staff member attempted to wake him at 11 pm. He was unresponsive and a MET call was made and emergency treatment provided. Arthur was pronounced deceased at 11.57 pm.³⁶

Health Ombudsman's findings

Arthur's case highlights the importance of quality, holistic care to patient outcomes and the need to treat all aspects of an individual's health—including their physical health—throughout the course of their admission. It also emphasises the devastating consequences for a patient when the core principles and responsibilities underlying collaborative and integrated care are not appropriately applied and implemented by health care providers.

My office has worked closely with CHHHS to determine that appropriate changes have been made by the hospital and health service, significantly improving the overall quality of the health care services provided to patients at the MHU.

This includes implementing a range of system changes and initiatives such as developing emergency department screening tools, improving interdepartmental transfer of patients experiencing mental illness, revision of 'time out' procedures, staff training, and introducing an integrated electronic records management system. I encourage CHHHS to continue to review and evaluate changes that have been implemented to improve the quality of services and treatment for patients with complex care needs, such as dual diagnosis.

Clinical incident management and analysis

Despite the intentions and best efforts of health services and health care workers, adverse events and patient harm can and does occur. To reduce the incidence of preventable patient harm, clinical incidents

³⁴ Work Instruction – Medical Emergencies, Cairns and Hinterland Mental Health & ATOD Service – Mental Health Unit, Queensland Health, Approved dated March 2011, V1.0.

³⁵ Vital observations are a single parameter system in which an emergency response is triggered when any single observation is outside a given range.

³⁶ CCTV Footage file 1 (length 10.01), High Dependency Unit activities room, 14 April 2015, commencing 9.16 pm.

need to be effectively managed; this includes applying principles of patient centred care, safe and just culture, consistency and fairness, a team approach, and confidentiality.

In July 2013, the individual hospital and health services (HHS) became responsible for local decision-making about how to best manage and respond to patient safety incidents within their health service area. Under the National Safety and Quality Health Service Standards for accreditation, it is mandatory for hospitals and health services to have systems to ensure patient safety incidents are recognised, reported, analysed and improvements identified.³⁷

At the time of Arthur's death, the procedure, *Dealing with the suicide or unexpected death of a consumer*, described the expectations and staff responsibilities when a patient dies unexpectedly in the MHU. The procedure explained that the 'Mental Health Patient Safety Officer will coordinate the incident analysis in accordance with the Clinical Incident Management Implementation Standard'. This required the incident to be analysed using an RCA methodology³⁸ and this was commissioned on 21 May 2015 by the CHHHS chief executive.

Information supplied by CHHHS and the northern coroner, including continuous closed circuit television (CCTV) footage³⁹ and patient progress notes, provide details of the clinical incident and confirm Arthur was attended by a staff member at 11 pm, that cardio pulmonary resuscitation (CPR) was commenced at 11.09 pm, and that CPR ceased at 11.59 pm.

Incident analysis is an integral part of the incident management process. It aims to determine what happened; how and why it happened; what can be done to reduce the risk of recurrence; and generates recommendations which, when implemented and evaluated, will enhance safe care.

Health Ombudsman's findings

The RCA method of clinical incident analysis conducted by CHHHS was consistent with the policy requirements at the time of Arthur's death. Shortly after Arthur's death, the CHHHS introduced a clinical incident management procedure in August 2015, which was revised in March 2017. The procedure provides detailed information describing the processes and responsibilities associated with recognising, reporting and analysing incidents according to their severity assessment classification (SAC) and refers to how recommendations arising from an incident analysis are to be managed and monitored. Clinical incidents resulting in death or likely permanent harm which is not reasonably expected as an outcome of health is categorised as a SAC1 event.⁴⁰

At the time of the incident, the Department of Health's (DoH) Health Service Directive—Patient Safety required all clinical analysis reports for the most serious clinical incidents to be submitted to the patient

³⁷ Best practice guide to clinical incident management, First edition-June 2014, Department of Health, Queensland Government.

³⁸ An RCA was the accepted methodology for clinical incidents resulting in death or permanent loss of function according to The Clinical Incident Management Implementation Standard required. A documented explanation was required for any alternative analysis method undertaken.

³⁹ CCTV Footage file 1 (length 10.01), High Dependency Unit activities room, 14 April 2015, commencing 9.16 pm.

⁴⁰ Best practice guide to clinical incident management, First edition – June 2014, Queensland Health.

safety unit within 90 calendar days of the incident being reported.⁴¹ This timeframe has remained an ongoing reporting requirement and is now referenced in the current CHHHS procedure.

The RCA conducted by CHHHS included a comprehensive review of the clinical incident and identified health care factors that contributed to Arthur's death. The RCA report made recommendations to improve health care and also made 'lessons learnt' recommendations; these recommendations identify corrective actions in response to issues that have not directly contributed to the patient's adverse outcome but represent an opportunity for service improvement.

However, my office noted there was a considerable delay of 37 days following Arthur's death, before the RCA was commissioned. Ideally, the RCA team would collect information for analysis, including conducting interviews, as soon as reasonably possible after the incident. This minimises the risk of important information being lost, memories fading, or individual recollections blurring or becoming contaminated through discussions with others⁴².

The RCA report was finalised and authorised by the commissioning authority on 28 October 2015; this was 160 days after the RCA was commissioned and well above the 90 days required by DoH. I also note the time taken to conduct the RCA was above the 2012–13 median time of 152 days, calculated by the Health Quality and Complaints Commission for comparable reviews in both the public and private hospital and health services in Queensland.⁴³

The 90 day timeframe aims to provide a reasonable period of time for a clinical analysis of a serious adverse event to be completed and improvements to be identified. A prompt response enables recommendations and corrective actions to be implemented as quickly as possible and reduces the likelihood of a similar event happening again.

Since Arthur's death, the CHHHS have introduced a new incident management procedure and revised the management of incident analysis processes. My office has reviewed the timeframes of eight RCA reports conducted by CHHHS since 2016 and can confirm that all reports have been completed within the 90 day timeframe.

I encourage CHHHS to continue to conduct regular reviews and evaluations of clinical incident management processes to ensure clinical incident analysis is commenced and conducted in a timely manner.

⁴¹ Health Service Directive, Patient Safety, V1, effective from 17 June 2013, Queensland Government.

⁴² Best practice guide to clinical incident management, First edition – June 2014, Queensland Health.

⁴³ Health Quality and Complaints Commission, Closing the Loop - Learning from reportable event review, March 2014.

Open disclosure

It is a mandatory accreditation requirement that health service organisations use an open disclosure program consistent with the Australian Open Disclosure Framework (the framework) and that it acts to improve the effectiveness of open disclosure processes.⁴⁴

The framework describes open disclosure as inherently complex, however it explains that if it is undertaken in a formal and systematic manner 'it can assist health service organisations to manage adverse events compassionately and provide broader benefits through improved clinical communication and systems improvements'.

The elements of formal open disclosure involve:

- a factual explanation of what happened
- an apology or expression of regret
- an opportunity for the patient and/or their family and carers to speak about their experience
- a discussion of the potential consequences of the adverse event
- an explanation of the steps being taken to manage the adverse event and prevent recurrence.

Open disclosure has an important role in health care quality improvement; it relies on and complements clinical incident analysis by providing a patient, family and carer perspective of the incident and may include suggestions for improving service provision.⁴⁵

It is important that a clinician acknowledges to the patient, family and carers, as early as possible, that something unexpected has occurred. This initial discussion represents the beginning of open disclosure and assists to build trust and reassurance to those affected.⁴⁶

At the time of Arthur's death, the CHHHS procedure, *Dealing with the suicide or unexpected death of a consumer*, described this initial meeting as 'clinical disclosure'. The procedure included a reference to the consideration of implementing formal open disclosure, however this process was not described in the procedure nor did it include a reference to the framework.

It is noted however, CHHHS introduced the procedure, *Open disclosure process*, effective from 25 November 2015 and revised in December 2016, which provided a description of the formal open disclosure process, training requirements and roles and responsibilities of staff.

The first of two formal open disclosure meetings initiated by CHHHS and held with the complainant occurred on the afternoon of 29 April 2015. This meeting took place just outside of the two week timeframe nominated in the current procedure. During this meeting CHHHS offered an apology and

⁴⁴ NSQHSS, Second Edition, Clinical Governance Standard, Patient safety and quality systems, Item 1.12.

⁴⁵ Australian Open Disclosure Framework – Better communication, a better way to care, Australian Commission on safety and Quality in health Care, 2013, p.10.

⁴⁶ Best practice guide to clinical incident management, First edition – June 2014, Department of Health, Queensland Government.

explained to the complainant that the hospital did not have answers to his questions, however he was advised 'the RCA investigation will be completed so this does not happen again'. The parties agreed the CHHHS would provide feedback from the RCA when this was completed.⁴⁷

A second open disclosure meeting occurred on 11 December 2015; this followed the finalisation and authorisation of the RCA report by the commissioning authority⁴⁸ on 28 October 2015, during which CHHHS presented the complainant with 'an overview of RCA process and recommendations and system improvements'. Meeting records indicate the complainant presented a document with excerpts from his son's medical records and sought answers regarding the medical care provided and the name of the treating doctor. CHHHS agreed to seek advice on the request for information and it was agreed CHHHS would follow this up and provide a response to the complainant.⁴⁹ CHHHS advised the office that the complainant had contacted the health service to follow up on his request for information and was informed the information he had requested concerning an individual practitioner could not be disclosed.⁵⁰

During the meeting between senior office staff and the complainant on 31 August 2017, the complainant discussed his experience with the open disclosure process; he explained that in the first open disclosure meeting he felt he was dealing with lawyers, questions weren't answered and he was left feeling extremely distressed. Following this discussion, the office arranged for a further meeting to take place between CHHHS and the complainant to revisit elements of the open disclosure process; this occurred on 2 November 2017.

The complainant reported this meeting was conducted in a much more empathetic manner; he described the person leading the meeting as a 'compassionate man' who shared as much information as he was able and that he talked about improvements that had been implemented since Arthur's death. The complainant also reported he felt the meeting had been conducted in a manner that had tried to satisfy him as much as possible.

Health Ombudsman's findings

The open disclosure process is a challenging process for both clinicians and patients, their family and carers. At the time of Arthur's death, CHHHS did not have a procedure that advised staff on how this process was to be conducted or implemented.

It is evident CHHHS did not effectively communicate with the complainant regarding how they planned to manage open disclosure in the weeks following Arthur's death or advise realistic timeframes for the commencement and completion of the RCA report. Additionally, the content of the two open disclosure meetings did not appear to adequately address the complainant's questions or concerns at the time, however the third meeting appears to have done so.

⁴⁷ Open Disclosure Meeting Debrief held on 29 April 2015, documented by Patient Safety Quality Officer, dated 30 April 2017.

⁴⁸ The commissioning authority was the chief executive, CHHHS.

⁴⁹ File note, Patient Safety and Quality Officer, date 11 December 2015.

⁵⁰ Response to section 228 request for information provided by CHHHS on 21 September 201.

The CHHHS's records of the second open disclosure meeting indicate a one hour meeting took place that included a presentation of the RCA report findings and recommendations. However, the records indicate that during this meeting the complainant was focused on the care his son had received in the hours prior to his death and sought an explanation and information from CHHHS regarding his treatment.

While the meeting sought to provide the complainant with an update and explanation regarding the improvements identified in the RCA report, it does not appear to have addressed the concerns or expectations of the complainant at the time. A discussion aimed at addressing and attempting to satisfy the complainant's questions may have led to a more constructive and satisfying meeting for the complainant. The *Hospital and Health Services Boards Act 2011* (Qld) allows for the results of an RCA to be openly shared with patients, families and carers as part of the open disclosure process; this can include a written summary of the report, however no documented RCA findings or outcomes were provided to the complainant.⁵¹ A written summary of the RCA report's findings would have provided the complainant with an opportunity to reflect on and absorb the information presented during the meeting at a later time.

Open disclosure presents many challenges for the clinician in managing the needs of patients, their family and carers. The framework provides detailed information to assist health services to effectively engage with stakeholders to successfully implement all elements of open disclosure.

The complainant's confusion and dissatisfaction with the process could have been minimised or prevented had the CHHHS followed the recommended processes outlined in the framework, including:

- clearly explaining the incident and providing the known facts
- preparing and agreeing on an open disclosure plan with the complainant that included a commitment to providing timely information
- arranging additional meetings or discussions to ensure all elements of open disclosure were addressed
- providing the complainant with a written report of the RCA findings that could later be referred to.⁵²

Since the incident the CHHHS has introduced an open disclosure procedure which includes a detailed flowchart documenting the stages and decision points of the process; it also includes a number of templates for implementing different components of the process, including a letter and checklist.

However, it was noted the procedure does not include reference to, or minimum requirements for, a number of essential requirements, these are:

- the development of a plan with the patient, family or carer
- conducting open disclosure meetings in addition to the 'family meeting' held within two weeks of the clinical incident

⁵¹ Department of Health, Review of Root Cause Analysis Legislation, 2013, Queensland Government

⁵² Australian Open Disclosure Framework – Better communication, a better way to care, Australian Commission on safety and quality in health care, 2013, p.14-15.

- the provision of documented findings and outcomes from the clinical incident review or analysis to the patient, family and carers.

I recommend the CHHHS review the procedure to ensure it is aligned with the framework and clearly documents the expectations and requirements of clinicians when conducting open disclosure following a serious or unexpected adverse outcome.

Recommendation 1

I recommend:

- the CHHHS undertake a review of the open disclosure procedure to ensure all key elements of the Australian Open Disclosure Framework are referenced in the procedure and that training provided to staff on open disclosure is consistent with this procedure.

Corporate and clinical governance

Good governance is fundamental to good practice and is characterised by a well-managed organisation.⁵³ The critical role of governance systems and management processes in setting, monitoring and improving organisational performance is recognised through the National Safety and Quality Health Service Standards, standard 1 – Governance for Safety and Quality in Health Service Organisations. The aim of this standard is to ‘create integrated governance systems that maintain and improve the reliability and quality of patient care as well as improving patient outcomes’.⁵⁴

The CHHHS board is accountable to the Minister for Health and Parliament for the HHS’s performance and derives its authority to conduct the business of the organisation from the *Hospital and Health Boards Act 2011* (Qld). The board is responsible for corporate governance and formulates strategy, sets policy, delegates responsibility, oversees management, and ensures appropriate risk management and accountability arrangements are in place throughout the organisation.

Clinical governance is a component of corporate governance and ensures good clinical outcomes through accountability for the delivery of safe, effective, high quality and continuously improving health services. The CHHHS’s Clinical Council provides a formal mechanism for clinician involvement and input into strategic and governance matters by providing expert clinical knowledge and advice to the executive management team and board.⁵⁵

In accordance with the National Model Clinical Governance Framework, good governance is comprised of a number of essential elements, these are:

- governance, leadership and culture
- patient safety and quality improvements systems

⁵³ Department of Health Governance Framework, July 2017, Queensland Health.

⁵⁴ Fact Sheet, Standard 1 – Governance for safety and Quality in Health Service Organisations, Australian Commission on Safety and Quality in Health Care.

⁵⁵ Annual report 2016-17, Cairns and Hinterland Hospital and Health Service, Queensland Government.

- clinical performance and effectiveness
- safe environment for the delivery of care
- partnering with consumers.⁵⁶

During the site visit, staff from the office met with the board appointed chief executive, Ms Clare Douglas, and members of the executive management team, to gain a broader understanding of the current corporate and clinical governance arrangements and issues.

As noted earlier, there has been significant changes to the CHHHS governance with the resignation of the board on 19 September 2016 and appointment of an administrator to oversee the HHS until a new board was appointed in May 2017.⁵⁷

The office requested information be provided during this meeting on the following discussion points:

- CHHHS governance and organisational structure
- CHHHS's governance and reporting arrangements for oversight of recommendations arising from serious clinical incidents
- CHHHS's management and evaluation recommendations arising from clinical incident review or analysis
- any significant issues or changes that may have impacted on the implementation of recommendations.⁵⁸

Health Ombudsman's findings

The CHHHS's response to the discussion points—combined with information provided by clinicians during the site visit—demonstrated CHHHS's commitment to strengthening governance systems to deliver quality services and meet community needs. A number of governance initiatives focusing on leadership and culture across the HHS were presented, these included:

- the new board undertaking a comprehensive induction program in June 2017
- the realignment of executive portfolios to ensure clear accountabilities, effective collaboration and a focus on priorities as part of the *Embracing a Healthier Future* plan
- the restructure of the HHS's safety and quality governance arrangements to facilitate operational management of safety and quality issues; see [appendix 2](#) for an excerpt from the board induction that illustrates the flow of safety and quality information to and from the board
- strategies to share safety and quality learnings such as six weekly mental health symposiums with case presentations led by senior clinicians and question and answer sessions.

⁵⁶ National Model Clinical Governance Framework, 2017, Australian Commission on safety and quality in health care.

⁵⁷ Annual report 2016-17, Cairns and Hinterland Hospital and Health Service, Queensland Government.

⁵⁸ Correspondence dated 11 August 2017.

The CHHHS also discussed the 'safe wards model' recently introduced to the MHU to illustrate the HHS's commitment to developing a culture that promotes a safe environment for the delivery of care. During the site visit, CHHHS staff expanded on and discussed in detail a number of initiatives—presented in the RCA updates—that have been introduced to ensure the MHU staff have the right clinical skills and qualifications to perform effectively and deliver safe and high quality care.

It is evident the safety and quality governance changes made by CHHHS have strengthened patient safety and quality improvement systems, in particular clinical incident management systems and the timely implementation of meaningful recommendations. CHHHS acknowledged in June 2017 that a significant number of recommendations arising from SAC1 incidents, many of which related to mental health, had not been implemented within the recommendation's nominated timeframe.⁵⁹

During the site visit, a number of staff explained that, prior to the recent changes, they would be advised of recommendations arising from SAC1 incidents without any consultation on the suitability or effectiveness of the recommendation. In addition, there had been no clear process or system for reporting or monitoring the implementation status of recommendations that had been assigned to individual staff members. This was supported by a staff member who explained that, when she commenced in her senior management role, she became aware of recommendations she was responsible for and went about implementing them without any oversight or defined reporting requirement.

This was strongly reinforced in the findings of the Health Service Review of the Mental Health and Alcohol and Other Drugs Service (MHATODS) report which stated that the MHATODS had been 'more than adequately reviewed, assessed and reported upon in recent times. However, some but not all the recommendations have been initiated, despite a variety of action plans and well documented operational and strategic intentions seeming to be in place'.⁶⁰

The CHHHS's current incident management procedure and safety and quality governance structure provide a framework for the development, approval, delegation and implementation monitoring of recommendations. This framework now requires consultation on all recommendations through newly formed speciality working groups to ensure specific, measurable, achievable and realistic recommendations are developed to effectively address the contributing factors and risks identified during the incident review or analysis process. It also ensures accountability for the implementation of recommendations through reporting processes.

It is evident to me CHHHS has introduced a number of key changes to ensure the effective integration of corporate and clinical governance systems that meet the essential elements of good governance. I encourage the CHHHS board and leadership teams to continue to review and evaluate governance systems to ensure the HHS continues to achieve the best possible health outcomes for Queenslanders seeking care within its region.

I am satisfied initiatives introduced by CHHHS to improve the quality and timely implementation of recommendations have resulted in a more effective patient safety and quality improvement system. However, due to the seriousness of the issues identified regarding the management of

⁵⁹ CHHHS Board Induction, Safety and Quality, June 2017.

⁶⁰ Health Service Review of the Mental Health and Alcohol and Other Drugs Service, CHHHS, January 2017.

recommendations, I recommend a further review to be conducted in 12 months' time to ensure recommendations arising from mental health SAC1 incidents and other relevant reviews and/or investigations are appropriate and implemented in a timely manner.

Recommendation 2

I recommend:

- the Office of the Health Ombudsman conduct a review in 12 months' time to ensure recommendations arising from mental health SAC1 incidents and other relevant reviews and/or investigations are appropriate and implemented in a timely manner.

Conclusion and recommendations

As Health Ombudsman and on behalf of this office, I would like to thank the CHHHS for their cooperation throughout the duration of this investigation; this has involved the collation and provision of extensive documentation, assistance in arranging the three day site visit program, and the willingness of staff to meet with my staff to discuss the HHS's governance arrangements and changes arising from the recommendations.

I would especially like to thank Arthur's family for their patience with the office during this lengthy investigation. Additionally, I acknowledge the complainant's ongoing advocacy for his son and other patients of the Cairns Hospital MHU.

Arthur was a young man with the dual diagnosis of schizophrenia and polysubstance use who unexpectedly died while he was an inpatient of the MHU at Cairns Hospital.

The CHHHS conducted a comprehensive review into the causes of the clinical incident and reported the findings and recommendations in an RCA report. I am satisfied with the quality of the CHHHS's review and have focused this office's investigation on the CHHHS's response to the 15 recommendations arising from the RCA. This investigation has determined that all 15 recommendations have been 'fully implemented', resulting in improvements that will prevent a similar incident occurring at the Cairns Hospital.

Due to the RCA's privacy restrictions this investigation report cannot provide any details regarding the RCA report's findings or recommendations. However, the scope of this office's investigation allowed for a number of additional issues to be explored and discussed in the report. These issues are also relevant to other health services and by sharing the learnings from this incident it may encourage other HHS's to review and make further improvements within their own health service.

The issues identified and discussed in this investigation highlight a number of challenging and complex issues, however it is reassuring to note that the CHHHS has governance systems in place that will enable ongoing improvements to be implemented.

Accordingly, this investigation report has made two recommendations to encourage CHHHS to continue to establish and implement integrated quality governance systems. The office intends to monitor the

implementation of the recommendations in accordance with the recommendation monitoring plan developed in agreement with CHHHS.

Full list of recommendations

No.	Recommendation
1	The CHHHS undertake a review of the open disclosure procedure to ensure all key elements of the Australian Open Disclosure Framework are referenced in the procedure and that training provided to staff on open disclosure is consistent with this procedure.
2	The Office of the Health Ombudsman conduct a review in 12 months' time to ensure recommendations arising from mental health SAC1 incidents and other relevant reviews and/or investigations are appropriate and implemented in a timely manner.

Submission from CHHHS in response to report

The office provided CHHHS with a draft of this report prior to its publication, inviting submissions about comments that could be construed as adverse to them and feedback on the draft recommendations and proposed recommendation monitoring plan.

CHHHS acknowledged the report and the office's intention to provide a copy of the final investigation report to Arthur's parents and to publish a condensed version of the report, and advised:

The CHHHS does not propose to make a submission pursuant to section 86(3) of the *Health Ombudsman Act 2013* and looks forward to working collaboratively with the OHO to monitor the implementation of the recommendations.⁶¹

⁶¹ Correspondence received the Chief Executive, CHHHS, dated 13 March 2018.

Glossary

AHPRA	Australian Health Practitioner Regulation Agency
ATODS	Alcohol Tobacco and Other Drugs Service
CHHHS	Cairns and Hinterland Hospital and Health Service
ED	Emergency Department
GP	General Practitioner
ITO	Involuntary Treatment Order
LDU	Low Dependency Unit
MET	Medical Emergency Team
MHATODS	Mental Health and Alcohol Tobacco and Other Drugs Service
MHU	Mental Health Unit
PICU	Psychiatric Intensive Care Unit
RCA	Root Cause Analysis
SAC	Severity Assessment Classification

Appendix 1—Definition of implementation status types

Implementation status	Definition	Considerations
Fully implemented	Evidence provided satisfactorily demonstrates recommendation has been fully implemented.	The action taken by the health service provider (HSP) meets the intent of the recommendation and sufficient evidence was provided to demonstrate action taken.
Partially implemented	Evidence provided does not adequately demonstrate recommendation has been fully implemented.	<p>This status encompasses three considerations:</p> <ol style="list-style-type: none"> 1. Action taken was less extensive than recommended, the action either fell short of the intent of the recommendation or only addressed some of the identified risks. 2. The HSP may have established a process to address an issue, however the specific action noted in the recommendation was not complete at the time of the assessment. 3. The HSP may have commenced action to address a recommendation but subsequent policy changes may influence how it might be implemented. <p>The office may be satisfied that no further reporting is required and the following additional note will be attached to the status: <i>The OHO is satisfied implementation of the recommendation is in progress.</i></p>
Not implemented	Evidence provided does not adequately demonstrate progress has been made toward implementing the recommendation.	<p>This category encompasses two considerations:</p> <ol style="list-style-type: none"> 1. There is no supporting evidence that action has been undertaken. 2. The action taken does not address the recommendation.

Appendix 2—Safety and quality in practice

(Excerpt from CHHHS board induction, June 2017)

