2016
ASIA PACIFIC CORONERS' SOCIETY CONFERENCE

PAN PACIFIC HOTEL PERTH, WA | 8 - 11 NOVEMBER 2016

Prevention in Practice

Asia Pacific Coroners Society Conference 2016

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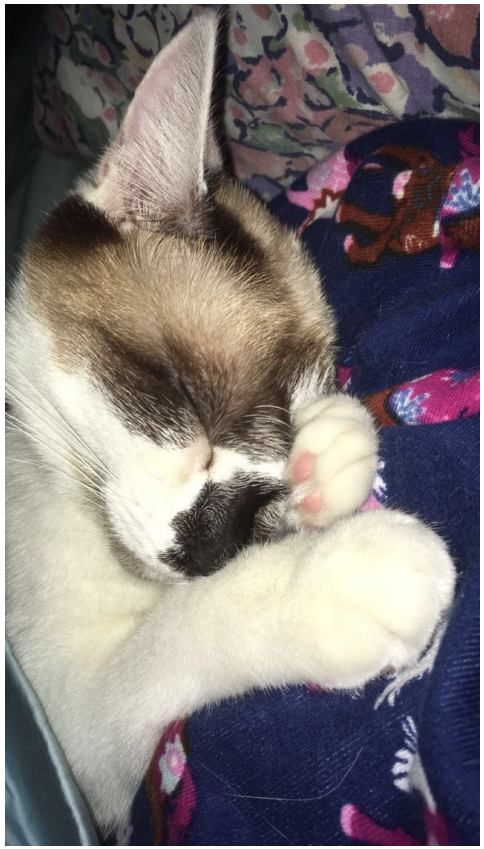
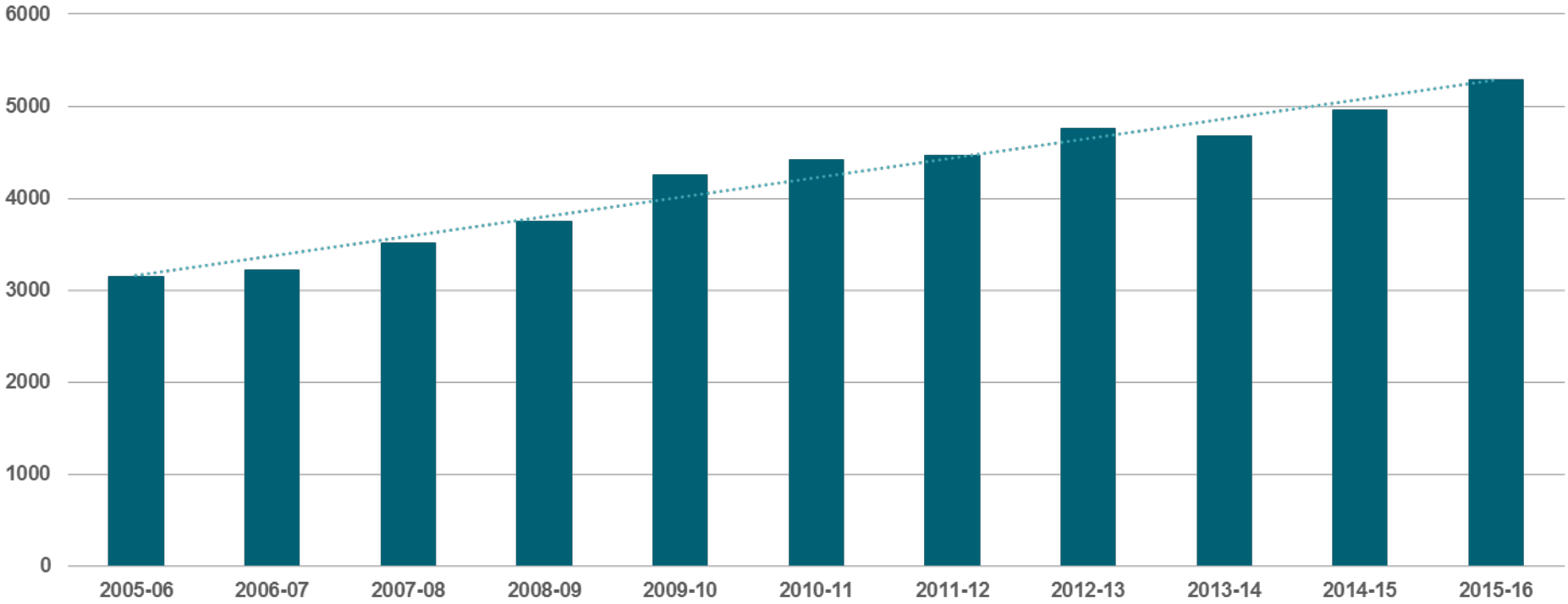
Queensland Government



Not Waving but Drowning..

Queensland's coronial system is experiencing steadily increasing demand

Total number of deaths reported to Queensland Coroners per financial year



Let the Right One(s) In

Queensland's innovative preliminary investigation processes actively triage reported deaths

"Form 1A" process

(direct reporting of potentially health care or fall related deaths)

"Natural causes triage" process

(apparent natural causes deaths where no cause of death certificate)

Collaborative multidisciplinary partnership between coronial + clinical forensic medicine + forensic pathology + clinical forensic nursing + coronial counselling resources

Clinical Forensic Medicine in the Queensland coronial system

What is Clinical Forensic Medicine?

- a medical specialty concerned with collection and interpretation of medical evidence
- primarily among the living
- derived through physical examinations, examinations of records or through review of other media

Role with the Coroner

- Identify outcome changing events in clinical pathways that lead to death
- Interpret toxicology (antemortem and postmortem)
- Respond to family questions around care
- Issues relating to care of those in Custody

Preventative gatekeeping

Geared to prevent system overload

BUT

can and does contribute to future death prevention

even when deaths are diverted from full coronial investigation

by **identifying patient safety issues**

through input from

independent Clinical Forensic Medical Officers

Form 1A Pathway

Reporting Doctor or Hospital

Coroner

Clinical information gathering

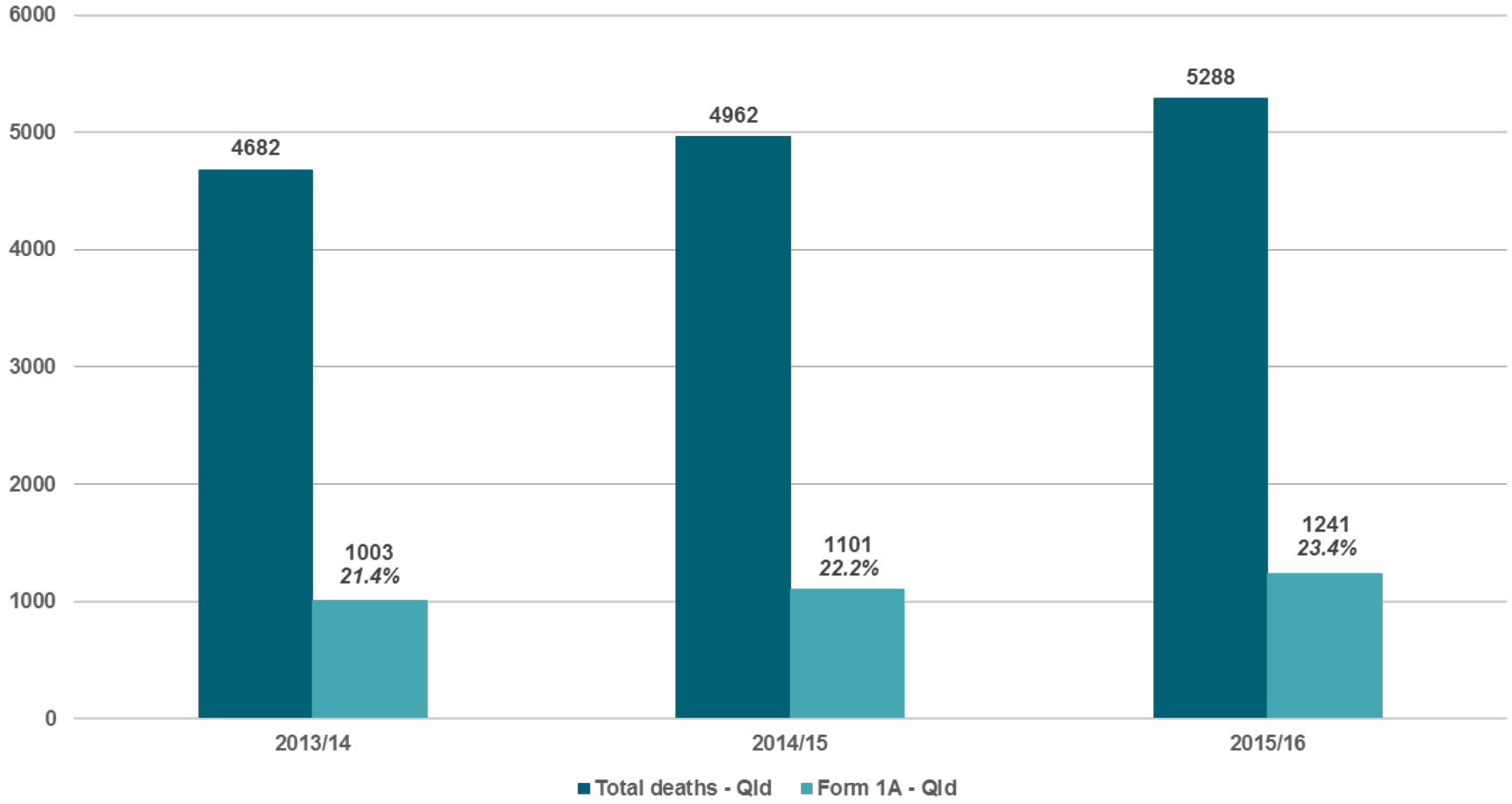
Forensic Medical Officer

Coroner

Capacity to engage with family through counsellors + input from duty pathologist to inform decision making

Reporting Doctor or Hospital

Form 1A deaths: 2013-2016



Questions informed by FMO input to Form 1A pathway

Is there sufficient information to support proposed probable cause of death?

If yes, coronial autopsy not warranted

Are there clinical management issues warranting further coronial investigation?

Were there opportunities to have prevented the death?

If yes, further coronial investigation (even without internal examination of body) may be warranted

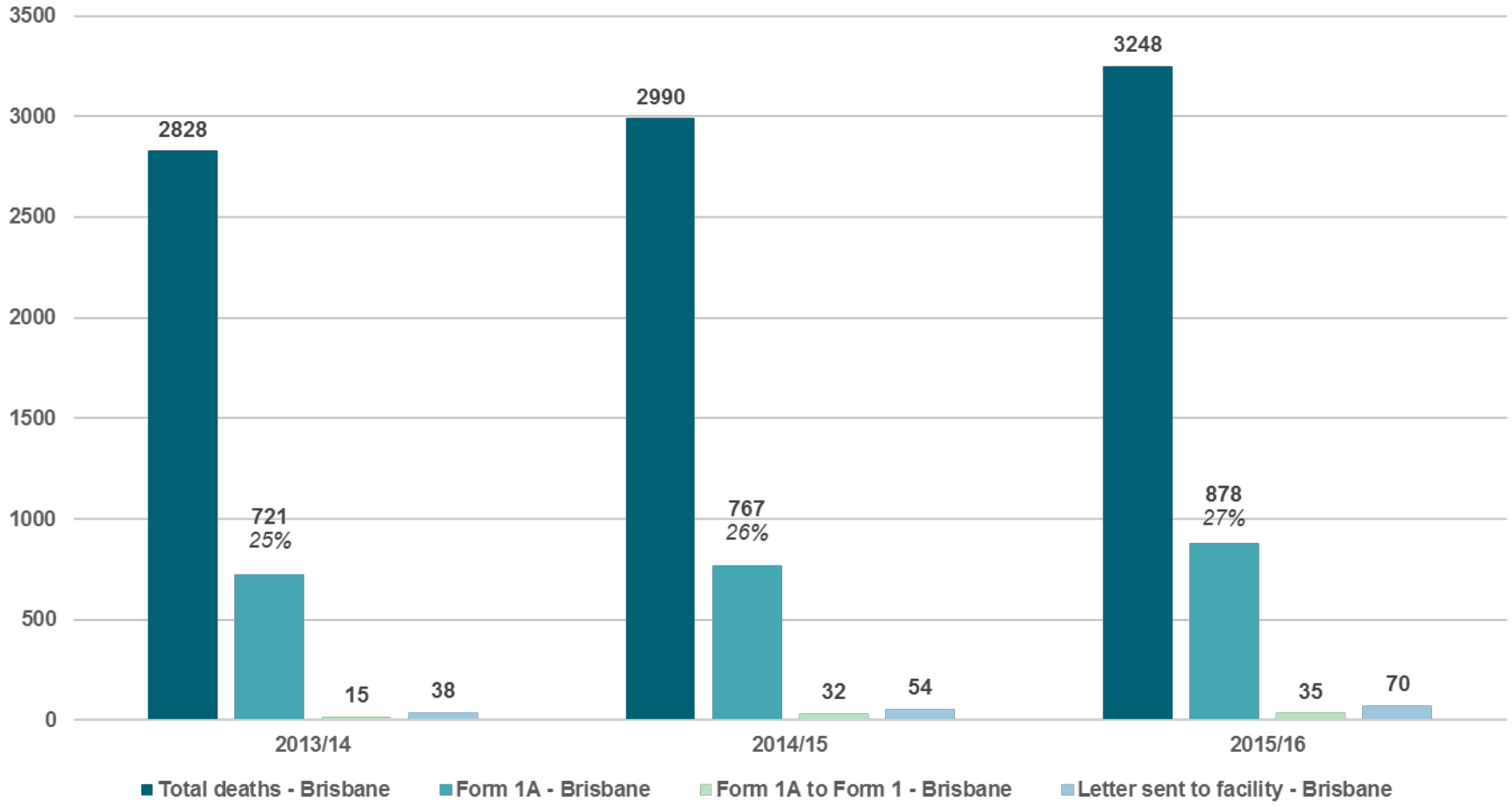
Forensic Medical Officer Review

- **Principles:**
  - Develop a timeline
  - Avoid ‘retrospectoscope’
  - Maintain a balanced view
  - Focus on outcome changing events
  - Note deficiencies in care even if not outcome changing
  - Opinion with a basis
  - Seek peer support
- **Medical records review including**:
  - Medical entries, Nursing entries, Allied Health entries
  - Medication Chart
  - Results of Investigations, Referrals, Discharge summaries
- **Family or other concerns (medical)**

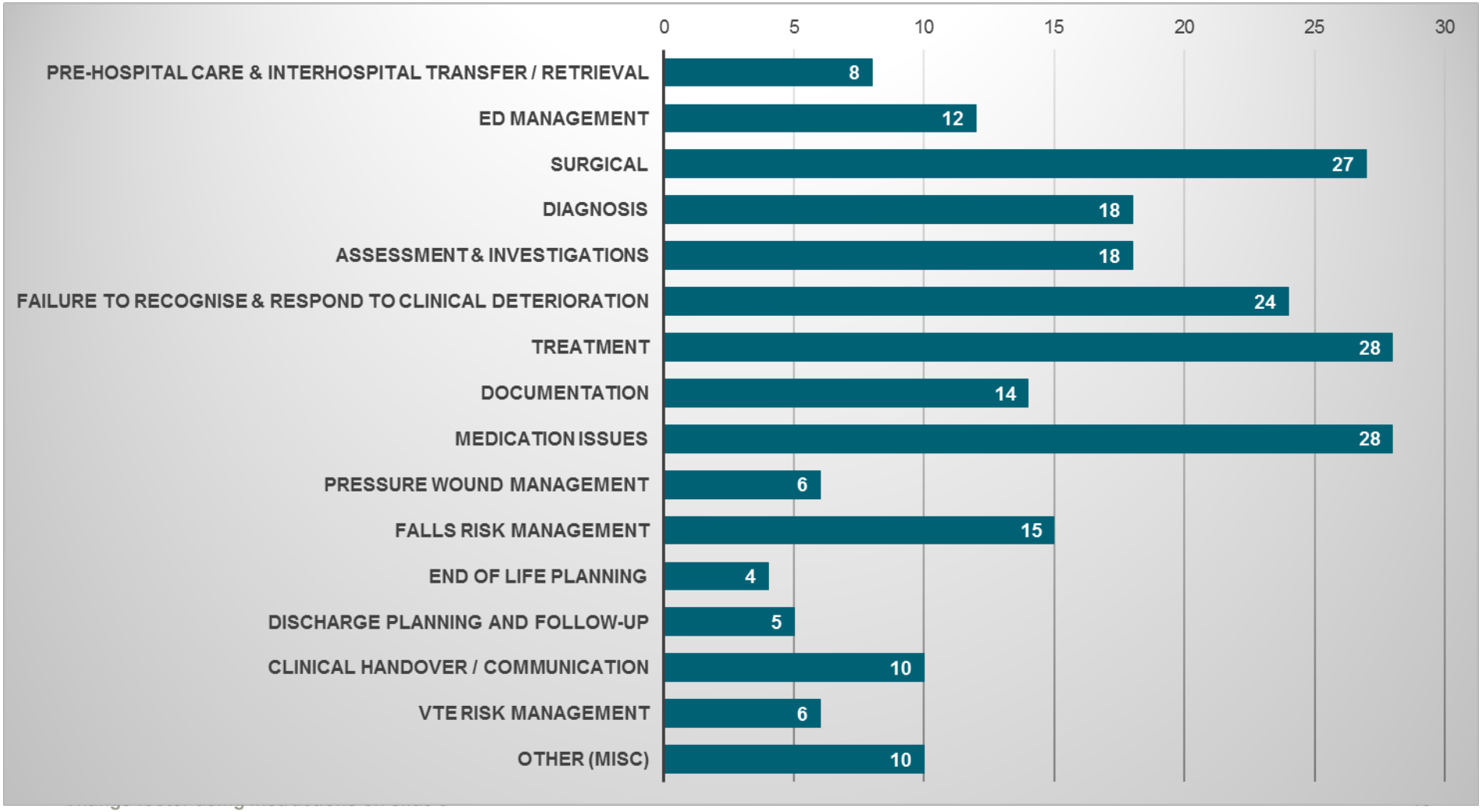
Forensic Medical Officer Report

- **Summary opinion identifies:**
  - Outcome changing events
  - Consent and capacity (known complications)
  - Quality of care issues (even if not outcome changing)
  - Answers to family questions
  - Limitations of advice
    - Specialist opinion
  - Same day turnaround

Form 1A outcomes (Registrar catchment): 2013-16



You've Got Mail! Love, Ainslie xx



The “Love, Ainslie” Effect?

Why bother?

- Over 50% yielded formal health service provider response
- Of these, some formal clinical review has been undertaken with varying degrees of independence from treating team
- Of these, 70% acknowledge the clinical management issues and demonstrate action taken to address them
- Interesting recent trend…

The “Love, Ainslie” Effect?

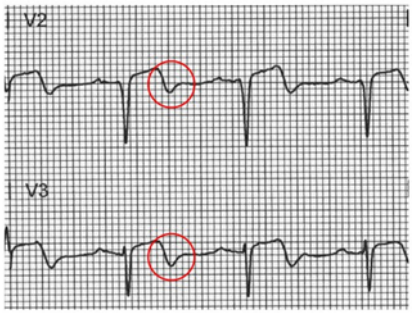
Case in point

- **45 year old male presents to a rural hospital**
  - Intermittent, burning chest pain
  - Examination normal
  - ECG performed
- **Provisional diagnosis: Reflux**
  - Referred back to GP
- **GP Presentation 1 week later**
  - Ongoing chest pain, worse with spicy foods
  - ECG performed

Case in Point

- **1 month later experienced an out of hospital cardiac arrest**
  - Resuscitated
  - Acute myocardial infarction diagnosed
  - Transferred to tertiary hospital and stent inserted
  - Hypoxic brain injury from long down time
  - Comfort cares and death
  - Referred to Coroner

- **CFMU review:**
  - ECG taken in hospital changed from previous ECG
  - ECG performed by GP abnormal also
  - Consistent with poor blood flow to a specific part of heart
  - Nil documentation regarding ECG interpretation



ems12lead.com - Wellens' Syndrome

Case In Point

- **Coronial Outcome**
  - Root Cause Analysis
  - Subsequent practice changes
    - ECG sighted and signed
    - Interpretation documented
    - Education specifically regarding Wellen's syndrome
  - Individual practitioner
    - Influenced by number of cases seen that day
    - Attended an ECG workshop

Food for thought

- **Would same patient safety improvements have been achieved through local clinical incident management processes in any event?**
- **Report back to Coroners Court is reliant on care provider goodwill – no power to compel response**
- **Power to re-open coronial investigation if new information received**
- **No findings but other means to report publicly eg Annual Report, clinical communique – role of health regulators?**
- **Limited capacity for trend analysis (unless you are Victorian coroners)**