

RTI 2400 – Hospital and Health Service Deaths in the Emergency Department (ED)

Purpose of report

The purpose of this report is to provide state-wide data regarding ED deaths that have been recorded in the Clinical incident reporting system, presented by Facility level as per request RTI 2400. The data is reported for 01 January 2013 to 14 May 2014.

Data source

- The data presented in this report is extracted from PRIME CI.
- PRIME CI is the Clinical Incident component of the PRIME information system. It is designed to enable reporting, investigation and management of clinical incidents reported by HHS staff.
- The data was extracted on the 13th June 2014 and is subject to change.
- State-wide data has been extracted, by Facility.

Limitations to consider in reviewing this report

- Sensitive patient, staff and clinician information is contained within these reports.
- Data is self-reported by HHS staff.
- PRIME CI does not capture incidents in Ambulances; the Queensland Ambulance Service has their own reporting system.

Data Extracted

- Time period: 01 January 2013 to 14 May 2014.
- ED deaths that have been recorded in the Clinical incident reporting system where the patient died in the ED AND the clinical incident reported occurred in the ED/Room.
- Facilities and/or months with zero relevant ED deaths (plus Ambulance deaths outside ED) are not included in the data table.

Results

- There are three (3) ED deaths that have been recorded in the Clinical incident reporting system that meet the criteria.

Facility	When Incident Reported
[REDACTED]	[REDACTED] 2013
[REDACTED]	[REDACTED] 2013
[REDACTED]	[REDACTED] 2014

The department is also aware of the following death that occurred in the ED. Whilst this death occurred in the ED it was identified that the death may be attributable to care received at another hospital prior to admission to the ED. This death was not identified using the above search criteria in PRIME CI as it was reported by the health service where the death may be attributable and this incident was reported against the ward where the patient received treatment (not an Emergency Department).

Facility	When Incident Reported
[REDACTED]	[REDACTED] 2013

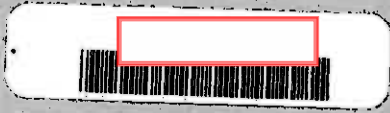
Date range 01/01/2013- 14/05/2014				Data extracted : 13th June 2014	
Date of incident	Incident ID	HHS	Facility	Ward	Notes
[redacted] 2013	[redacted]	[redacted]	[redacted]	Emergency Room	Client presented with femoral arterial occlusion [redacted] [redacted] The Medical Officer discussed treatment options with the patient. The patient refused possible [redacted] Risks of lysis were discussed including checklist for contraindications. The patient was lysed. Following lysis the patient gained some low grade return of circulation [redacted] However the patient subsequently deteriorated rapidly and became unconscious which led to death.
[redacted] 2013	[redacted]	[redacted]	[redacted]	Emergency Department (A&E)	Unexpected death of an eighty six year old [redacted] four hours after presenting to the Emergency room at [redacted]
[redacted] 2014	[redacted]	[redacted]	[redacted]	Emergency Department - ED	pt presented at [redacted] 2014 with an [redacted] overdose [redacted] was monitored overnight.at 0640 [redacted] escorted to mental health room to wait for formal mental health assessment. Pt checked by staff at 0735 not breathing immediate action(s) taken 0735 cardiac arrest code called.resus team arrived quickly. full resus for an hour Result of immediate action(s) resus for 1 hour unable to regain cardiac rhythm
[redacted] 2013	[redacted]	[redacted]	[redacted]	Division of Medicine Ward/Area - [redacted]	Child admitted [redacted] /2013, first episode of brief seizure, cough and some [redacted] hea. No further seizures or fevers noted, discharged [redacted] [redacted] 2013. [redacted] [redacted] QAS called, taken to [redacted] under resuscitation which continued until [redacted] No cardiac rythem/outout ever obtained, deceased at [redacted] and coroner notified. [redacted] EDMS contacted [redacted] EDMS with notification. [redacted] to review

Redactions have been made under s.47(3)(b) of the RTI Act - release could identify individuals and is contrary to the public interest.

CONF. DELETED BY BARTS

[redacted] 13.

[redacted]



Department RecFind No: [redacted]
Division/HHS: [redacted]
File Ref No: [redacted]

16AA

Briefing Note for Noting
The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED
DATE [redacted] 2013

Requested by: Chief Executive,
[redacted] Hospital & Health Service

Date requested [redacted] 2013

Action required by:

SUBJECT: Alleged sexual assault of a patient [redacted]

Recommendation
That the Minister:

RECEIVED [redacted] 2013
OLD HEALTH

Note allegations of sexual assault of a [redacted] patient by other patients within the [redacted] and subsequent actions of the [redacted] Hospital and Health Service (HHS).

Note [redacted] reported the alleged assaults to [redacted] Police on [redacted] 2013. The Executive Director [redacted] and [redacted] HHS was notified of this on [redacted] 2013.

Note an urgent interview on [redacted] 2013, with [redacted] by the Chief Executive and the Executive Director [redacted] indicated this was part of long term bullying behaviours within the facility by other patients that had not been resolved by [redacted] or escalated to senior management.

Note immediate internal review and disciplinary procedures have commenced.

APPROVED/NOT APPROVED

NOTED

NOTED

LAWRENCE SPRINGBORG
Minister for Health

RECORDS TEAM
RECEIVED [redacted] 2013
DEPT. OF HEALTH

Chief of Staff
[redacted] 113

Minister's comments

Briefing note rating

1 2 3 4 5
1 = (poorly written, little value, and unclear why brief was submitted). 5 = (concise, key points are explained well, makes sense)
Please Note: All ratings will be recorded and will be used to inform executive performance.

URGENT

2013

Page 1 of 3

Department RecFind No:	
Division/HHS:	HHS
File Ref No:	

Briefing Note for Noting Director-General

Requested by: Chief Executive,
Hospital & Health Service

Date requested: 2013

Action required by:

SUBJECT: Alleged sexual assault of a patient in

Proposal

That the A/Director-General:

Note allegations of sexual assault of a patient by other patients within the and subsequent actions of the Hospital and Health Service (HHS).

Provide this brief to the Minister for information.

Urgency

1. Critical - of have reported this incident to the Police and consequential actions of the HHS will result in significant immediate changes at the

Headline Issues

2. The top issues are:

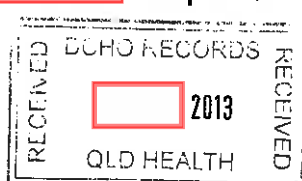
- reported incidents of alleged sexual assault of by some other inpatients (more than one) to the Police on 2013.
- An urgent interview on 2013, with by the Chief Executive and Executive Director indicated this was part of long term bullying behaviours within the facility by other patients that had not been resolved by the or escalated to senior management.
- Immediate internal review of the facts and disciplinary procedures have commenced.

Blueprint

3. How does this align with the *Blueprint for Better Healthcare in Queensland*?
 - Health services focused on patients and people.

Key issues

4. 2013, the Executive Director was advised that of a of had made allegations to the that had been sexually assaulted by other patients of One of the alleged perpetrators is a
5. Appropriate monitoring and surveillance of the patients has been instituted
6. In the course of delineating the alleged assault incidents raised a range of other serious concerns they had regarding clinical care and the responsiveness of to clinical incidents.
- 7.



Department RecFind No:	
Division/HHS:	HHS
File Ref No:	

8. [redacted] (Private Investigators external to the HHS) have been engaged and interviewed [redacted] 2013, to gain an accurate and formal statement. Appropriate reporting has been made to Australian Health Practitioner Regulation Agency (AHPRA) and to the Crime and Misconduct Commission (CMC) and other professional regulation bodies as relevant.

9. [redacted]

10. [redacted]

11. [redacted]

12. A communication strategy is being prepared in relation to this situation.

Background

13. The [redacted] model of care has been under review at a statewide level and comprehensive service planning and consultation has occurred [redacted]

14. There have been an ongoing number of clinical incidents within [redacted] that have not responded to corrective action to date.

15. Following concerns raised by [redacted] 2013, that [redacted] was unsafe in [redacted] immediate arrangements were made [redacted] by the Executive Director for the constant supervision of [redacted]

16. The Chief Executive, the Executive Director [redacted] and the Executive Director of Workforce from [redacted] HHS met with [redacted] to clarify concerns.

17. [redacted] primarily raised issues of alleged bullying and sexual behaviours of other patients towards [redacted] and noted that their concerns were first raised some months ago with [redacted] staff. The issues were escalated [redacted] to [redacted] and [redacted] concurred that the Police should be notified. However, [redacted] did not progress or escalate this issue within the HHS.

18. [redacted] have also raised concerns with communication, record keeping, follow-up and duty of care of staff to keep [redacted] safe.

19. [redacted] have comprehensive notes of the issues they have raised with specific staff, which will be utilised to assist in the review the HHS has commissioned.

20. Senior staff were spoken with and informed that the HHS takes these allegations extremely seriously and will undertake an immediate investigation.

Consultation

21. Department of Health: The Acting Director-General, and the Director of [redacted] Executive Director of the [redacted] have been consulted and support actions outlined.

Attachments

22. Nil

Department RecFind No:	
Division/HHS:	HHS
File Ref No:	

Recommendation

That the A/Director-General:

Note allegations of sexual assault of a [redacted] patient by other patients within the [redacted] and subsequent actions of the [redacted] Hospital and Health Service (HHS).

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED

NOTED



DR MICHAEL CLEARY
A/Director-General

[redacted], 2013

To Minister's Office For Noting ☐

A/Director-General's comments

Author

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Content verified by: (CEO/DDG/Div Head)

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CONF

8/7/13

QC03/021414

Department RecFind No:	BR057088
Division/HHS:	South West HHS
File Ref No:	

9

Briefing Note for Noting

The Honourable Lawrence Springborg MP
Minister for Health



RECEIVED

8 JUL 2013

Requested by: Ministers office

Date requested: 3 July 2013

Action required by: 3 July 2013

SUBJECT: Preliminary Legionella findings at Charleville Hospital and Waroona Nursing Home

Recommendation

That the Minister:

Note the actions being taken at Charleville Hospital and Waroona Aged Care Facility to treat water supply following the receipt of preliminary test results which show high levels of Legionella.

Note funding is being provided out of existing South West Hospital and Health Service State funding.

Note the high risk of plumbing failure should shower heads need to be removed for disinfection or replacement.

APPROVED/NOT APPROVED

NOTED

NOTED

LAWRENCE SPRINGBORG
Minister for Health



Chief of Staff

117 V3

Minister's comments

Briefing note rating

1 2 3 4 5

1 = (poorly written, little value, and unclear why brief was submitted). 5 = (concise, key points are explained well, makes sense)
Please Note: All ratings will be recorded and will be used to inform executive performance.

DOH-DL 13/14-036

Document No. 5

URGENT

Department RecFind No:	BR057088
Division/HHS:	South West HHS
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Ministers office

Date requested: 3 July 2013

Action required by: 3 July 2013

SUBJECT: Preliminary Legionella findings at Charleville Hospital and Waroona Nursing Home

Proposal

That the Director-General:

Note the actions being undertaken at Charleville around preliminary Legionella results.

Provide this brief to the Minister for information.

Urgency

1. **Critical** – significant risk of adverse media attention.

Headline Issues

2. The top issues are:

- Preliminary Legionella testing results were received today for a large percentage of the samples taken at Charleville Hospital and Waroona Aged Care Facility. Indicative results include a large percentage of positive readings including some at levels of 7,300 and 6,100 CFU/ml of Legionella Pneumophila SG215, and in the 600-750 CFU/ml range for Legionella Pneumophila SG1.
- Due to the high levels of results (that is, up to 730 times the reporting rate), the laboratory provided advice that we should chlorinate the water supply immediately. This advice was supported by the Darling Downs Public Health Unit.
- Operating theatre closed with theatre list postponed; no caesarean capacity with theatre closed, three mothers due to birth imminently have been moved from Charleville; dental list has been postponed; Department of Health and Ageing has been notified as Waroona Aged Care Facility affected.

Blueprint

3. How does this align with the Blueprint for Better Healthcare in Queensland?
 - Delivery best patient care.

Key issues

4. Whilst these results are only preliminary, so won't be formally released by Chief Health Office until Friday, 12 July 2013, the high preliminary levels have led to immediate remedial action.
5. Media release has been circulated today to all media outlets.
6. To minimise staff concerns, all staff have received a communiqué and fact sheet from the Chief Executive and staff meetings have been held on-site at Charleville Hospital and Waroona Aged Care Facility today to advise staff of the proposed action.
7. Patients affected are:
 - 16 patients on the dental list at Charleville for today (4 July 2013) and tomorrow (5 July 2013) have had their appointments postponed;
 - 10 scheduled general surgery cases for 8 July 2013, have been postponed;
 - four gynaecology theatre cases scheduled for 10 July 2013, have been postponed;

Department RecFind No:	BR057088
Division/HHS:	South West HHS
File Ref No:	

- three expectant mothers, with births imminent have been transferred out of Charleville as there is no caesarean capacity whilst the theatre is closed; and
 - four inpatients of the hospital and 45 residents at Waroona Nursing Home are unable to be showered.
8. As the test result levels indicated, additional to chlorine disinfection, the Departmental Guidelines for response direct that shower heads should be dismantled and disinfected or replaced. This is problematic and highly risky at Charleville Hospital due to the severely impaired condition of the current plumbing at Charleville. The internal pipework is copper piping installed in the 1930's. This pipe is currently very thin-walled and has been the subject of repeated briefings requesting funding for replacement. Under the current Rural and Remote Infrastructure Project, \$3 million was allocated to Charleville Hospital. This funding was insufficient to replace all of the pipe work. Replacement of the full pipe work may have to be reconsidered in line with the Legionella results and resultant longer term risks.
9. Due to the high risk of pipe work failure, shower heads are not being dismantled or replaced at this stage. Further water sampling will occur post chlorination and if Legionella species results are still high, replacement of shower heads will then be attempted.

Background

10. Legionella testing is being undertaken across South West Hospital and Health Service in line with the Minister's direction.
11. Charleville Hospital, Waroona Aged Care Facility, Roma Hospital, Westhaven Aged Care Facility and St George Hospital were tested in the week beginning 24 June 2013. Mungindi MPHS, Dirranbandi MPHS, Mitchell MPHS, Augathella MPHs and Morven Outpatients Clinics have been tested this week.
12. It is intended the remaining health facilities in South West Hospital and Health Service will be tested over the next two weeks.

Consultation

13. Darling Downs Public Health Unit; Media Unit

Attachments

14. Attachment 1: Finalised media release (already approved by Minister's Office)

Department RecFind No:	BR057088
Division/HHS:	South West HHS
File Ref No:	

Recommendation

That the Director-General:

Note the actions being undertaken at Charleville around preliminary Legionella results.**Provide** this brief to the Minister for information.

APPROVED/NOT APPROVED

NOTED


 DR TONY O'CONNELL
 Director-General

81 71 13

To Minister's Office For Noting ☒

Director-General's comments

 Author
 Meryl Brumpton

Chief Operations Officer

South West Hospital and Health Service


 3 July 2013

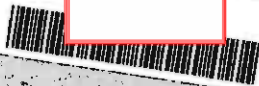
 Content verified by: (CEO/DDG/Div Head)
 Graem Kelly

Chief Executive

South West HHS

4624 2853


 3 July 2013



Department RecFind No:
Division/HHS:
File Ref No:

10

Briefing Note

The Honourable Lawrence Springborg MP
Minister for Health



Requested by: Chief Executive, [redacted]
[redacted] Hospital and Health Services

Date requested: [redacted] 2013

Action required by: [redacted] 2013

SUBJECT: Child death in the Emergency Department at [redacted]

Recommendation That the Minister:

Note that on [redacted] 2013, a [redacted] old child died in the Emergency Department at [redacted]. After arrival by the Queensland Ambulance Service, [redacted] staff provided full resuscitation to the child for 40 minutes, unfortunately the child did not show any signs of recovery and was declared dead at [redacted] 2013.

Note that the Queensland Coroner has been informed and will undertake an investigation.

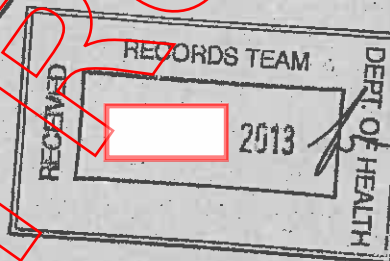
Note that the child was discharged from [redacted] on [redacted] 2013, following a [redacted] admission for seizure and febrile illness.

APPROVED/NOT APPROVED

NOTED

NOTED

LAWRENCE SPRINGBORG
Minister for Health



Chief of Staff

31913

Minister's comments

PLS KEEP THIS OFFICE APPRISED OF THE INVESTIGATIONS OUTCOMES

Briefing note rating

1 2 3 4 5

1 = (poorly written, little value, and unclear why brief was submitted) 5 = (concise, key points are explained well, makes sense)
Please Note: All ratings will be recorded and will be used to inform executive performance.

URGENT

Department RecFind No:	
Division/HHS:	
File Ref No:	

Briefing Note for Noting Director-General

2013

Requested by: Chief Executive,
 Hospital and Health ServicesDate requested: 2013Action required by: 2013**SUBJECT: Child death in the Emergency Department at**

Proposal

That the Acting Director-General:

Note that a child was declared dead at 2013, after being transported to by the Queensland Ambulance Service (QAS) following discharge from that morning.

Provide this brief to the Minister for information.

Urgency

1. **Critical** - there are major public relation considerations due to the nature of the death.

Headline Issues

2. The top issues are:

- on old child died in the Emergency Department, after resuscitation attempts during transport by QAS staff and then continued by Emergency staff were unsuccessful
- the Queensland Coroner has been informed and will undertake an investigation
- the child was discharged from on the morning of 2013, following a admission for seizure and febrile illness.

Blueprint

3. How does this align with the *Blueprint for Better Healthcare in Queensland*?
 - Transparency promotes public confidence.

Key issues

4. QAS was called to old child QAS staff resuscitated the child for 20 minutes prior to arriving at 2013.
5. staff provided full resuscitation to the child for 40 minutes, unfortunately the child did not show any signs of recovery and was declared dead at 2013.
6. Police and the Queensland Coroner were notified of the death.
7. The Executive Director, Medical Services (EDMS), notified the EDMS, who has confirmed via email that the are investigating the case.

Background

8. holds details of prior treatment of the child and can provide these on request.

Consultation

9. Director,
10. EDMS,

Attachments

11. Attachment 1: Serious Safety Event Brief

Department RecFind No:	
Division/HHS:	
File Ref No:	

Recommendation

That the Acting Director-General:

Note that a child was declared dead at [] on [] 2013, after being transported to [] by the Queensland Ambulance Service (QAS) following discharge from [] that morning.

Provide this brief to the Minister for information.

APPROVED/NOT APPROVED

NOTED

Michael Cleary
 DR MICHAEL CLEARY
 Acting Director-General

[] 2013

Acting Director-General's comments

To Minister's Office For Noting ☒

Author

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Cleared by:

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Content verified by: (CEO/DDG/Div Head)

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Serious Safety Event Brief

People | Service | Safety & Quality | Value | Research

Patient Safety and Quality Service

Date: 2013

Time:

Prepared by:

Target audience ☒ GMO & Chief Executive Officer

☒ Board Chair

☐ Other – please specify

Action:

☒ For information

☐ Other – please specify

Are there any immediate risks related to this incident that require briefing to the Director-General?

☒ Yes ☐ No

I advise that the following Serious Safety Event has occurred in 13

Event type:

Unexpected death within 24 hours of discharge

Description of the event (What happened?): Please provide a brief description of what happened and what immediate actions have been taken (DO NOT IDENTIFY STAFF OR PATIENT).

admitted to /13 under . Presented with the first episode of a brief generalized seizure. Initially mottled and hypothermic but no focal signs. Cough and some diarrhea. Given iv fluids and antibiotics and admitted to . Adenovirus on nasopharyngeal aspirate, other investigations were negative (normal blood tests, urine culture grew mixed flora, stool pending). The child was observed and reported as appearing well by medical and nursing staff with no fevers or further seizure episodes. The child was feeding with normal vital signs. discharged home following consultant review on the morning of 13.

arrived . Ambulance was called and with resuscitation, arriving at DEM at where resuscitation was continued until . They proceeded rhythm/output was ever obtained. Efforts were ceased at and the coroner notified.

Clinical care: What support has commenced?

Child's GP has been notified

Disclosure:

Clinician Disclosure will occur.

Senior clinical staff have spoken to the patient/family?

☒ Yes ☐ No

If No, select reason:

☐ Patient / Family / Carer refused

☐ No known next of kin

☐ Unable to contact next of kin at this stage, progressing search

Formal Open Disclosure will occur.

☒ Yes ☐ No

Formal Open Disclosure Team planning meeting date. To be advised

Coronial Requirements

Did the patient die?

☒ Yes ☐ No

If Yes, was the death reported to the Coroner?

☒ Yes ☐ No

Authorisation:

This reportable event will be subject to a RCA?

☒ Yes ☐ No

If No, please state reason and alternate plan for analysis:

Name:

Signature:

Date: 13

Designation: