Safer Care
Victoria

Court ref: COR 2015 004707

12/10/17

Ali Frazer
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
Southbank VIC 3000
cpuresponses@coronerscourt.vic.gov.au

Dear Ali,

Re: Investigation into the death of Lynsie Maree Everett

Thank you for your letter dated 19 July 2017 which includes a copy of the finding into death without inquest regarding the death of Lynsie Maree Everett and the subsequent recommendations made by Deputy State Coroner Iain West.

Safer Care Victoria responds to the recommendations as follows:

Recommendation 1: That the Department of Health and Human Services (DHHS) and Safer Care Victoria (SCV) be informed of the issues identified by a review of the circumstances of Ms Everett's death at Swan Hill District Health (SHDH) namely;

a) The severity and complexity of Ms Everett's septic condition was not fully appreciated, which led to her remaining in the care of a rural hospital that was unsupported by a high dependency or intensive care unit.
b) The medical and nursing staff did not recognise, respond to Ms Everett's deteriorating respiratory condition and escalate appropriately.
c) The possible contributing factors included an assumption that deranges liver function tests were alcohol related and a misinterpretation of respiratory related symptoms clouded by past familiarity with her anxiety symptoms when hospitalised.
d) Once Ms Everett collapses, a MET code was called, rather than a Code Blue. There appeared to be no doctor present at the resuscitation possessing advanced airway skills, not was one called.

Recommendation 1 has been implemented. SCV and DHHS have been informed of the issues identified by a review of the circumstances of Ms Everett's death and the key findings of the investigation as detailed by the coroner. SCV and DHHS have disseminated the findings through the following means:

- The SCV Chief Medical Officer chaired a meeting in which relevant managers and senior leaders from DHHS discussed the circumstances that led to the death of Ms Everett, the findings of the coroner and how the findings relate to current and future programs of work at SCV and DHHS. Examples of work relevant work discussed include the MET/Rapid Response Quality Improvement Project led by the Critical Care Clinical Network and the planned work regarding capability in Urgent Care Centres. This meeting recognised that the contributing factors that led to the death of Ms Everett are not necessarily unique to SHDH. A summary and full copy of the coroner's report was sent to the attendees of this meeting, with instruction to circulate within their teams.

- The death of Ms Everett, the coroner's findings and progression against the recommendations were discussed and noted at the meeting of the SCV issue management group.
- SCV has ensured the DHHS Loddon Mallee regional manager was informed of the findings and has been involved in the ongoing discussions between SCV and DHHS.

Recommendation 2: That the Department of Health and Human Services and Safer Care Victoria, strengthen and support Swan Hill District Health be providing the requires resources and training to address these issues.

An alternative to the Recommendation 2 has been implemented.

Through the conversations the SCV Chief Clinical Officers and Directors have had with the DHHS Loddon Mallee rural health branch, SCV employees and with SHDH directly, I am pleased to acknowledge that SHDH has undertaken a significant amount of work over the past two years to improve and strengthen the systems and response to clinical deterioration since the death of Ms Everett.

I would also like to note the recent successful accreditation survey achieved by SHDH against the National Safety and Quality Health Service Standards in September 2017. During this survey, SHDH reportedly received very positive feedback about their medical emergency response system within *Standard 9: recognising and responding to clinical deterioration in acute health care.* SCV has requested to view a copy of the accreditation report from SHDH. SCV has also asked SHDH to provide examples of the improvement work that they have undertaken in relation to clinical deterioration and escalation of care.

I will be personally visiting SHDH on 1 December 2017 with a colleague from SCV with expertise in clinical governance, acute clinical management, escalation and deterioration. During this visit we will meet with the Chief Executive Officer of SHDH, E. C (Ted) Rayment, clinical and non-clinical managers, front line staff and will tour the facilities. We will discuss the specific findings of the coroner, the improvement work undertaken by SHDH and the areas requiring ongoing improvement.

SCV has offered to provide ongoing support to SHDH in recognising and responding to clinical deterioration as requested and directed by the service. This includes access to the range of improvement activities that have been driven by the Victorian Emergency / Critical Care and Sepsis Clinical Networks. Opportunities that SHDH can access relevant to responding to clinical deterioration include:

- the work of the Critical Care Network Subcommittee to establish resources to standardise and support the training, process and documentation for responders to clinical deterioration.
- an educational DVD for responders and MET developed by the Australian and New Zealand Intensive Care Society. The clinical network can assist in accessing resources from the college as required.
- specialist expertise that can be sourced through the clinical networks. Bendigo and Austin Health both have experts in the recognising and responding to clinical deterioration space.
- a self-assessment tool that will assist with benchmarking against the national consensus statement (can be made available via the network).

Ultimately, the Critical Care Network aims to establish a data base to assist with benchmarking and supporting non-intensive care unit sites (such as SHDH) and to provide SCV with line of sight of the presentations and activities in this area. This work remains underway and will be closely linked to the work of the Victorian Agency for Health Information and changes to the Victorian Incident Information Management System.

SCV
Safer Care
Victoria

I thank you for bringing to the attention of SCV and DHHS the issues that led to the death of Ms Everett. The findings and review of the circumstances are a harrowing reminder of the importance of supporting health services to determine capability and escalate appropriately to ensure the safety of people in our care.

Yours sincerely,

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