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REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Territory Coroner's Findings and recommendations regarding the death of Ms Joanne Craig

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Pursuant to section 46B of the *Coroners Act 1993*, I provide this Report on the findings and recommendations of Local Court Judge Greg Cavanagh, the Territory Coroner, dated 20 September 2019, regarding the death of Ms Joanne Craig (the Deceased) (Attachment A refers).

The Report includes the response to the recommendations from the Chief Executive Officer (CEO) of the Department of Health.

The Deceased, a 57 year old woman of Aboriginal descent, died at 9:25 pm on 24 January 2018, at Katherine District Hospital, Katherine in the Northern Territory. The cause of death was multi-organ failure due to sepsis as a result of a Streptococcus pneumoniae infection.

Recommendations of the Territory Coroner

Pursuant to section 35 of the *Coroners Act 1993*, the Territory Coroner made the following recommendations in regards to the death of the Deceased:

'67. **I recommend** that General Practitioners have a schedule for and make every effort to provide to Aboriginal and Torres Strait Islander people the Pneumovax23 (23vPPV) vaccination in accordance with the Australian Immunisation Handbook.

68. **I recommend** that the Top End Health Service do all things necessary to ensure its staff are competent in the recognition of sepsis and escalation of treatment and that such efforts are ongoing.

69. **I recommend** that the Top End Health Service do all things necessary to ensure that the documentation utilised when treating patients is appropriate and appropriately utilised.

70. **I recommend** that documentation utilised be audited on a regular basis.'

Responses to Territory Coroner's recommendations

A copy of the Coronial Findings was provided to the CEO of the Department of Health on 14 October 2019 in accordance with section 46A(1) of the *Coroners Act 1993*.

A written response was received from the CEO of the Department of Health dated 20 December 2019, as required by section 46B(1) of the *Coroners Act 1993* (Attachment B refers). A follow up to the written response was received on 16 January 2020. Together, the response from the Department of Health is as follows:

- In response to the recommendation at paragraph 67 of the Coronial findings:

  This recommendation generally concerns general practitioners (GPs). NT Health has no jurisdiction over GPs except ensuring that they meet criteria to provide National Immunisation Program (NIP) vaccines.

  Pneumovax23 is recommended for Aboriginal and Torres Strait Islander people on the NIP and so is available to GPs free of charge for clients who meet the criteria.

  GPs will only be provided NIP vaccines after the Centre for Disease Control audits a GP clinic and provides education and resources.

  NT Health notes that even where the Pneumovax23 is offered in accordance with the NIP, the patient still needs to consent to receive the vaccine.

- In response to the recommendation at paragraph 68 of the Coronial findings:

  The NT Health Sepsis Working Group (Working Group) has had two meetings since its formation on 27 September 2019 and has set an action plan and are finalising its budget and communications plan. The NT Health sepsis campaign will have a strong focus on remote and primary health care

  Aboriginal health will be a priority for quality improvement activities conducted by the Working Group.

  The Working Group is due to submit its first progress report in March 2020.

  In the interim, the Top End Health Service reports that it:

  - continues to undertake work outlined in its submission to the Coronial Inquiry in September 2019;
  - has undertaken Detecting deterioration, Evaluation, Treatment, Escalation, and Communicating in Teams (DETECT) Courses for 2019 which aim to educate staff to recognise clinical deterioration in a patient and has expanded its provision of DETECT courses compared to 2018;
  - is awaiting the implementation of the NSW Clinical Excellence Commission's Sepsis Education Program by NT Health so it can commence the roll out of the program;

- has incorporated sepsis into its Pulse Deteriorating Patient Scenario training sessions conducted by Intensive Care unit clinicians across Royal Darwin Hospital and Palmerston Regional Hospital;
- has initiated the distribution of 'Stop Sepsis' posters following the Top End Health Service Safety and Quality forum on 11 December 2019; and
- has collaborated with the 'T for Thomas' foundation to launch the NT Health Sepsis Management Plan on 13 September 2019. The Katherine Hospital World Sepsis Day was also celebrated on this day with activities conducted throughout the week, including the promotion of the NT Health Sepsis Pathway and the 'REACT' system of patient and family escalation of care.

- In response to the recommendation at paragraph 69 of the Coronial findings:

  The Top End Health Service reports that:

  - it continues to coordinate the implementation of the Sepsis Pathway through the Working Group;
  - the review of Sepsis Pathways for paediatrics and other specialty areas is ongoing;
  - the current Sepsis Pathway form and Severe Sepsis guideline have been in place for less than 12 months and the usage and distribution of the forms across the Top End Health Service continues to be monitored; and
  - the Sepsis Pathway is being used in all Top End Health Service acute facilities.

- In response to the recommendation at paragraph 70 of the Coronial findings:

  The Top End Health Service continues to audit the Sepsis Pathway.

  The Royal Darwin Hospital and Palmerston Regional Hospital audit of the Sepsis Pathway found:

  - there are sustained improvements in allocation of the most serious and urgent triage care and the timely provision of antibiotics;
  - high rates of admission to hospital and critical care environments imply that this patient group will likely benefit from timely care;
  - there is no evidence to suggest over-treating or inappropriate use of antibiotics for those well enough for discharge or admission to the extended emergency medicine unit; and
  - there was a need for simplifying the pathway for staff to follow and to make the recognition criteria more prominent.

The audit conducted at the Katherine Hospital found:

- 50 per cent of people that have an infection, sepsis or septic shock had the septic pathway form completed;
- 100 per cent of people with a completed sepsis pathway form had blood cultures taken versus 70 per cent in the group without a completed sepsis pathway form; and
- over 90 per cent of patients, regardless of sepsis pathway form completion, received timely provision of antibiotics.

The results of these audits were documented at the Working Group.

I am satisfied that the Department of Health has considered the recommendations of the Territory Coroner and is taking the necessary steps with respect to those recommendations.

DATE: 24 JAN 2024

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