2020

THE LEGISLATIVE ASSEMBLY FOR THE

AUSTRALIAN CAPITAL TERRITORY

ACT GOVERNMENT RESPONSE TO CORONER'S FINDINGS FROM THE INQUEST INTO THE DEATH OF THEADORA ZAAL

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7 May 2020

ACT Government Response to Coroner's findings from the *Inquest into the death of Theadora Zaal*

Executive Summary

On 6 November 2019, ACT Coroner Boss delivered her report in response to matters of public safety in relation to the *Inquest into the death of Theodora Zaal.*

Coroner Boss found Ms Zaal died on 7 August 2015 from cardiac arrest following elective surgery at Calvary John James Hospital (CJJH).

Coroner Boss found two matters of public safety:

- Insufficient medical coverage of the wards; and
- A lack of appropriately trained staff in life saving technique.

Coroner Boss made four recommendations for CJJH:

- implement training and changes to procedure to ensure that where discretion is used to not make a Medical Emergency Team (MET) call, the discretions and reasons are formally recorded;
- audit central cardiac monitoring systems and defibrillators;
- undertake refresher training for staff on keeping accurate records and scribing during resuscitation; and
- consider rostering two resident medical officers (RMO) on duty to deal with emergencies during peak surgery times.

Background

Under section 57 of the *Coroners Act 1997*, a Government response is required as the report raises two matters of public safety. Coroner Boss' *Inquest into the death of Theodora Zaal* was referred to the ACT Government for response.

Both public and private health care facilities (HCFs) are licensed as a public health risk activity under the section 18 of the *Public Health Act 1997* in accordance with the Public Health (Health Care Facilities) Declaration 2001. Licensed HCFs must comply with minimum patient safety and reporting standards that are set out in the Health Care Facilities Code of Practice 2001 (CoP).

The Australian Commission on Safety and Quality in Health Care (the Commission) is established under the *National Health Reform Act 2011*. The Commission is responsible for developing the National Safety and Quality Health Service Standards (National Standards)[1]. ACT Health Directorate applies the National Standards as a recognised accreditation system for HCFs in the ACT.

At the time of Ms Zaal's death, CJJH held a HCF licence and accreditation to the National Standards. CJJH continues to hold a HCF licence and has maintained accreditation since Ms Zaal's death. At the time of Ms Zaal's death, the National Standards comprised of 10 standards, including two relevant standards outlined below.

[1] *National Health Reform Act 2011*, S8(1)

The relevant criteria under the National Standard *Governance for Safety and Quality in Health Service Organisations* include[2]:

- Performance and skills management - this includes the clinical workforce having the right qualifications, skills and approach to provide safe, high quality health care.
- Incident and complaints management - this involves patient safety and quality incidents been recognised, reported and analysed, this information is used to improve safety systems.

The relevant criteria under the National Standard *Recognising and Responding to Clinical Deterioration in Acute Health Care* include[3]:

- Establishing recognition and response systems - this involves organisation wide systems that are used to support and promote the recognition of and response to patients whose condition deteriorates in an acute HCF.
- Recognising clinical deterioration and escalating care - patients whose condition shows signs of deterioration should be recognised and action taken to escalate care.
- Responding to clinical deterioration - appropriate and timely care should be provided to patients whose condition is deteriorating.

Discussion

In response to the *Inquest into the death of Theodora Zaal,* Coroner Boss identified two public safety risks and made four recommendations to CJJH. The recommendations were made following the death of Ms Zaal who died from cardiac arrest in the context of aortic stenosis, coronary artery disease and left ventricular hypertrophy.

Public safety risks arising from the coronial report

1) Insufficient medical coverage of the wards

Under section 8.1 of the CoP, all HCFs must be staffed by an adequate number of health care professionals to ensure that occupant safety and care is maintained[4]. For the 2015-16 financial year, CJJH's reported to ACT Health Directorate: 157 beds; 191.26 full time equivalent (FTE) professional (clinical) staff; and 117.37 FTE non-professional (non-clinical) staff.

If there is insufficient medical coverage of the wards this may constitute a breach of the CoP, which HCFs are required to comply with in order to maintain their licence in the ACT. Following the death of Ms Zaal, ACT Health Directorate as the regulator was not advised by CJJH of any issues or instances concerning insufficient staff coverage. The regulator has not found CJJH to be non-compliant with the relevant standards of the CoP at the time of Ms Zaal's death.

The Chief Health Officer has written to the current CJJH licence holder to reiterate the facility's obligations as a HCF under the *Public Health Act 1997* and the CoP, including maintaining appropriate staffing levels. The regulator will work with all HCF licence holders to ensure ongoing compliance in this regard.

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[2] Australian Commission on Safety and Quality in Health Care. (2012) *National Safety and Quality Health Service Standards.* P14-15

[3] Australian Commission on Safety and Quality in Health Care. (2012) *National Safety and Quality Health Service Standards.*P60-61

[4] ACT Health Care Facilities Code of Practice 2001, S8.1, P8

2) A lack of appropriately trained staff in life saving technique

In 2015, CJJH was fully accredited to the National Standards, which the facility has maintained up to and including the present day. The National Standards include requirements for staff training regarding safety and quality in health service organisations (Standard 1) and recognising and responding to clinical deterioration in acute health care (Standard 9).

Following the death of Ms Zaal, CJJH advised the Coroner that CJJH had provided a supplementary training session to its Intensive Care Unit (ICU) staff in using a defibrillator, and from the end of 2019 the hospital implemented a plan to ensure all ICU staff were trained in advance life support.

Having received CJJH's advice on the above, the coroner's report stated, "On that basis I am satisfied that the risk to public safety in respect of the defibrillation process employed in the attempted resuscitation of Mrs Zaal is sufficiently ameliorated."

Coroner's recommendations to CJJH

The Coroner also made four recommendations to CJJH.

1) CJJH implement training and changes to procedures such that where a discretion is exercised to not make a MET call that is otherwise warranted, the exercise of that discretion and the reasons behind it should be formally recorded in the patient progress notes to put beyond doubt that patient warning signs have not been overlooked or disregarded accordingly.
2) CJJH undertake as a matter of priority an audit of its central cardiac monitoring systems and defibrillators to ensure that they are all operating correctly and that there is no discrepancy between the rhythms being detected on each machine when used on patients.
3) CJJH undertake refresher training of its staff as to the importance of keeping accurate records, and specifically, the need to properly scribe resuscitation efforts.
4) CJJH consider rostering two RMO's on duty to deal with emergencies during peak surgery times when many visiting medical officers and other doctors will be in surgery on other cases.

Each of the above recommendations was made directly to CJJH and are required by the National Standards. CJJH is surveyed for compliance against the National Standards by approved accrediting agencies to ensure they meet minimum patient safety and quality health service standards.

ACT Health Directorate is currently conducting a review of health care facility licensing and regulation in the ACT. The review will take into consideration the findings of Coroner Boss with a view to strengthening the requirements for health care facility reporting, investigation and response to adverse clinical events.