Inquest into the death of Dianne Judith Bowling

Dianne Judith Bowling died by intentionally ingesting various prescribed medications and in particular a toxic level of her antihypertensive medication metoprolol. Ms Bowling suffered a long-term debilitating mental illness and in the month prior to her death was experiencing a relapse and deterioration in her mental well-being.

Deputy State Coroner John Lock delivered his findings of inquest on 18 July 2014.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported.

The departments named in this response will provide implementation updates until the recommendation is delivered. Further information relating the implementation of recommendations can be obtained from the responsible minister named in the response.

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The policy supporting the introduction of acute management plans notes that the acute management plan is to be saved in Consumer Integrated Mental Health Application (CIMHA) and the Emergency Department Information System (EDIS) so that the most current plan is accessible to all mental health acute care teams, Department of Emergency Medicine and psychiatry services across the state. Provided that is the case then no further comment or recommendation appears to be necessary.

I assume that to ensure the efficacy of the new policy, a system of audits of compliance has been put in place. If not, then it should be.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

In the findings of inquest, the coroner described the strategies implemented by the Metro North Mental Health (MNMH) to ensure that mental health acute management plans (AMP) are accessible to clinicians within the service, including the Princes Charles Hospital (TPCH) department of emergency medicine. In this service, AMP are uploaded into a statewide database called the Consumer Integrated Mental Health Application (CIMHA) which allows clinicians to access relevant mental health information, and an alert is placed in in the TPCH Emergency Department Information System. Six monthly reviews of all acute management plan compares CIMHA and TPCH alerts for AMPs. The service will continue to monitor and audit the process.

However, the strategies implemented by MNMH are not routinely undertaken in other services around the state. The AMP is a locally developed document and is not uniform across Queensland. The addition of any new clinical documents to the statewide suite of clinical documents which might accessible via The Viewer requires careful consideration and consultation across the state's mental health services. The risk of adding another clinical management plan to those already in existence could lead to confusion amongst clinicians regarding which plan to refer to and problems with maintaining the currency of each plan. Over the next three months the Mental Health Alcohol and Other Drugs Branch will consult with MNMH regarding the AMP to consider its suitability for statewide application.

The Viewer is a web based database which allows clinicians statewide to access patient information. Unlike CIMHA, information available in The Viewer is not specific to mental health. In April 2015, to assist clinicians working outside the mental-health discipline, CIMHA was integrated to The Viewer to allow all authorised clinicians access to a range of mental-health related documents, including the consumer care review summary and plan, the crisis intervention plan and the recovery plan.

On 10 May 2016 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health will implement the recommendation through an alternative approach to achieve the same result.

Following statewide consultation with clinical experts regarding the suitability of the AMP, the Mental Health Alcohol and Other Drugs Branch progressed implementation activities to enable the AMP to be available in the CIMHA. Implementation into CIMHA will allow staff in emergency departments to access and view the AMP through a system called The Viewer.

The Viewer is a read-only web-based application that displays consolidated clinical information sourced from a number of existing Queensland Health enterprise clinical and administrative systems, including CIMHA. This is the preferred solution as the current functionality of EDIS requires the mental health clinician to manually add an alert, indicating there is an AMP. EDIS does not have capability to add an AMP form from CIMHA automatically.

The preferred approach allows access by emergency department staff to the most current plan available.

The Mental Health Alcohol and Other Drugs Branch is working in partnership with Metro North Mental Health Services to manage the implementation and ensure mental health staff understand how to complete the AMP and maintain its currency. Part of the implementation will include provision of information to services about the need for local processes to monitor and audit the development and maintenance of AMPs.

Minor refinements to the AMP is required to ensure its applicability across the state and the development of a resource guide to accompany the form will be finalised in 2016. The AMP will be incorporated into a broader set of CIMHA enhancements scheduled for 2016.

On 12 September 2016 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health progressed implementation of the recommendation through an alternative approach to achieve the same result. The Department's Mental Health Alcohol and Other Drugs Branch implemented the AMP into the suite of mental health clinical documentation available in CIMHA. Implementation into CIMHA will allow staff in mental health acute care teams, psychiatric services and staff in emergency departments to access and view the AMP through a system called The Viewer.

The AMP form has been refined and redesigned to ensure its applicability across the state. The revised AMP form was released on 30 April 2016, as part of the planned CIMHA enhancements.

The Queensland Centre for Mental Health Learning developed an eLearning package to accompany release of the form. A resource guide has also been developed to provide clinicians with a quick-reference tool to assist with completion of the form. Statewide consultation on the AMP form and resource guide has been undertaken with positive feedback received from hospital and health services.

The responsibility for auditing of clinical documentation lies with hospital and health services. Release of the AMP has been accompanied by promotional communication and a written statement by the chief psychiatrist. Hospital and health services are encouraged to utilise this resource and educational resources provided to further assist clinicians with the implementation of the AMP form and can easily audit clinician use through CIMHA.