Inquest into the deaths of Verris Dawn Wright and Jasmyn Louise Carter (Carter-Maher)

On 28 August 2015 Deputy State Coroner John Lock delivered his findings of the inquest into the deaths of Verris Dawn Wright and Jasmyn Louise Carter (Cater-Maher).

Ms Wright died from septic shock on 26 December 2013 at the Oakey Hospital. Ms Cater (Carter-Maher) died from meningococcal septicaemia on 4 August 2014 at the Warwick Hospital. The coroner investigated the overarching systemic issue of the clinical detection of a deteriorating patient and the adequacy of the hospital and health service's implementation of the Queensland Adult Deterioration System.

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.

Recommendation 1

Queensland Health provide sufficient funding to:

- conduct research into the validation of the Queensland Adult Deterioration Detection System (Q-ADDS) tool
- conduct research to identify and address the sociocultural factors that influence compliance with existing hospital care escalation systems.

Response and action: implementation of the recommendation is in progress.

Responsible agency: Queensland Health.

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

Queensland Health is searching for an organisation to conduct the research on the validation of Q-ADDS tool. More information about the implementation of this recommendation will be provided in mid-2016.

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

Queensland Health has conducted a request for information process to search for a suitable organisation to conduct the research on the validation of Q-ADDS tool.

Queensland Health will select a research organisation via a procurement process to undertake the research which is anticipated to commence in 2017 with an anticipated completion date of early 2018.

On 25 January 2018 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health progressed a request for offer to engage a consultant to conduct research to validate Q-ADDS, and identify and address the socio-cultural factors that influence compliance with existing hospital care escalation systems. Queensland Health will choose a research organisation with the research anticipated to commence shortly afterwards.

The Minister for Health and Minister for Ambulance Services updated:

Queensland Health has chosen a consultant to undertake the research to validate Q-ADDS tool, identify and address the socio-cultural factors that influence compliance with existing hospital care escalation systems.

The consultant will provide Queensland Health with updates as the research progresses.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

Central Queensland University is researching the validation of Q-ADDS to identify and address sociocultural factors that influence compliance with existing hospital care escalation systems. Ethics approval from the Gold Coast Hospital and Health Service Human Research Ethics Committee was granted to undertake the research.

There are two aspects of the research that will be undertaken in 2018. Part A of the research will involve a retrospective chart audit at hospitals across the state to determine the effectiveness of the Q-ADDS scoring system to detect adult clinical deterioration. Part B of the research will involve Queensland Health nurses completing an online survey and or volunteering to participate in confidential interviews. A research article for publication will be delivered at the finalisation of this research.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

During early 2018, Central Queensland University conducted the research by retrospective chart audits, online surveys and confidential interviews at various hospital and health services.

The research will continue, with a number of site visits occurring during the data collection phase. Interviews with staff associated with the social-cultural research will commence mid-2018 with the data analysed for publishing in 2019.

Recommendation 2

The Darling Downs Hospital and Health Service (DDHHS) consider a protocol for advising family of the deterioration of a patient immediately upon staff becoming aware of such deterioration, such that family can attend if possible or at least be aware and appraised of the condition of their loved one in a timely and ongoing way.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

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

Four DDHHS documents are in the process of being amended to draw the attention of clinicians to the need to notify family of any serious, life-threatening or significant unexpected deterioration in a patient's condition as soon as practically possible. More information about the implementation of this recommendation will be provided in mid-2016.

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

The update and implementation of DDHHS documents that draw the attention of clinicians to the need to notify family of any serious, life-threatening or significant unexpected deterioration in a patient's condition is completed.