Inquest into the death of Summer Alice Steer

Summer Alice Steer died on 30 June 2013 at the Royal Children's Hospital. Summer died from a haemorrhage due to an aorta oesophageal fistula, which was caused by the ingestion of a button battery that was lodged in her oesophagus.

Coroner John Hutton delivered his findings of inquest on 3 November 2015.

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 5

The Queensland Government collaborate with the button battery industry and product manufacturers, distributors and retailers to fund organisations such as the Office of Fair Trading and Kidsafe to conduct an ongoing active public awareness campaign to warn the public about the dangers of button batteries for children and practical ways to mitigate the risk.

Response and action: the recommendation is implemented.

Responsible agency: The Office of Fair Trading within the Department of Justice and Attorney-General, supported by Queensland Health, Australian Competition and Consumer Commission, other state and territories fair trading and consumer protection agencies.

The Office of Fair Trading is involved in a number of initiatives that relate to this recommendation. Whilst some are Queensland based, others are take on a more national focus.

1. The development of an industry guide

On 20 August 2016 the Attorney-General and Minister for Justice and Minister for Training and Skills responded:

Manufacturers and retailers of button batteries and products that use button batteries have developed a draft industry guide on the safe supply of these products. The guide covers such issues as child resistant packaging, safety labelling, battery security and safe disposal. The guide was sent to key stakeholders on 13 May 2016 for comment. The Office of Fair Trading is on the consultation list and currently considering the document. This has been an initiative of industry with some oversight by the Australian Competition and Consumer Commission. Once published, the industry guide will be used by industry and regulators as a benchmark for the safe supply of products that use button batteries.

On 25 February 2017, the Attorney-General and Minister for Justice and Minister for Training and Skills responded:

The voluntary Industry code on the safe supply of button batteries and products that use button batteries was published on the 29 July 2016. It was developed by retailers, associations, and product safety consultants with input from consumer product safety regulators. The code prescribes readily available safety features such as battery enclosures requiring a tool to gain access to the batteries.

The Office of Fair Trading is distributing the code to identified suppliers and throughout its stakeholder network. The industry code is being utilised by industry and regulators as a benchmark for the safe supply of products that contain button batteries.

2. Kidsafe Queensland education campaign

On 20 August 2016 the Attorney-General and Minister for Justice and Minister for Training and Skills responded:

In early 2016, Kidsafe Queensland received a grant from Queensland Health to conduct an education campaign during 2016 to raise parents' and caregivers' awareness of the dangers of button batteries. The campaign has a number of elements that cover educating parents and caregivers, working with product safety regulating agencies and promoting safe marketing practices to industry.

The Office of Fair Trading has worked closely with Kidsafe Queensland in developing a safety poster for use in child care centres, hospitals, doctors' surgeries and other venues where parents and caregivers of young children are likely to gather. The poster is currently being distributed to these locations and the Office of Fair Trading is assisting with this.

Importantly, the poster makes it clear that the first step for parents and caregivers, if they suspect a child has swallowed a button battery, is to contact the Poisons Information Centre urgently for advice. It is hoped to roll out this message nationally to promote a nationally consistent approach to consumer advice on suspected button battery ingestions. One key advantage of this approach is that the Poisons Information Centre can provide forward notice to hospitals advising that a child will be attending with a suspected button battery ingestion. This may assist with more timely diagnosis of button battery ingestions.

The Office of Fair Trading has also produced a consumer brochure to accompany the poster, which is currently being printed. These brochures will be used by Kidsafe Queensland and the Office of Fair Trading in outreach and stakeholder engagement activities throughout the State to promote button battery safety.

The brochure and poster will likely be adopted by other product safety regulators around the country.

On 25 February 2017, the Attorney-General and Minister for Justice and Minister for Training and Skills responded:

In June 2016 the Office of Fair Trading attended the Pregnancy, Babies & Children's Expo, the expo provided unparalleled opportunities for the Office of Fair Trading to deliver important safety messages to parents and caregivers when they are thinking of purchasing children's products. The Office of Fair Trading distributed 2000 button battery safety brochures to expectant parents, parents and caregivers and also conducted consumer education workshops on product safety issues that affect parents of children aged nine and under throughout the three day event with a particular focus on button battery safety.

The Office of Fair Trading has proactively conducted a number of outreach and stakeholder engagement activities throughout the state which has facilitated the distribution of the button battery safety poster and the associated consumer brochure to high risk groups such as primary schools (including kindergartens and preschools) and childcare centres. To date, 3036 brochures and 272 posters have been distributed, and schools and child care centres have been encouraged to order further copies if required.

The Office of Fair Trading has distributed a total of 750 button battery safety posters to the eight regional offices throughout the state for use in regional outreach and stakeholder engagement activities. Regional offices in Townsville, Mackay, Sunshine Coast, Gold Coast and Toowoomba have to date distributed 271 button battery safety brochures.

As part of Kidsafe Queensland's education campaign to raise parents' and caregivers' awareness of the dangers of button batteries the organisation has disseminated the following button battery safety collateral:

- 2,500 brochures distributed at the 2016 Pregnancy, Babies & Children Expo
- 100 posters & 5,000 brochures to the Lady Cilento Hospital
- 750 posters to Goodstart Early Learning Centres that have been distributed to 700 centres throughout Queensland
- 100 posters distributed to patient safety and quality improvement services (Queensland Health)
- 2,500 brochures and 100 posters were delivered to each of the primary health networks in Bundaberg, Maryborough, Gympie and Maroochydore
- 5,000 brochures and 750 posters delivered to each of the primary health networks in Ipswich, Toowoomba and Inala
- a PDF file version of both the brochure and poster have been shared with various health departments, the Poisons Information Centre and the Australian Competition and Consumer Commission.

3. The Office of Fair Trading's compliance strategy

On 20 August 2016 the Attorney-General and Minister for Justice and Minister for Training and Skills responded:

As part of the Office of Fair Trading's proactive product safety marketplace inspection plan, Office of Fair Trading inspectors have been checking retail outlets to identify and remove from sale products that do not have secure and tamperproof button battery compartments. Whilst this has had some success, in that several thousand products have been removed from sale, it has been recognised that this should be an ongoing and national activity and it will therefore be continued during 2016 - 17. A number of importers of products that use button batteries have agreed to change the design of their products to ensure the button battery compartments cannot be removed without the use of a tool.

On 25 February 2017, the Attorney-General and Minister for Justice and Minister for Training and Skills responded:

As part of the Office of Fair Trading's proactive industry compliance management and education program for 2016 – 2017, inspectors continued to proactively check suppliers to identify and remove from sale consumer products that do not comply with the industry code and also ensuring important safety information for safe use is incorporated on retail packaging, in point of sale material, and in user instructions.

As a result a number of importers and suppliers of products that contain button batteries have agreed to change the design of their products to ensure the button battery compartments cannot be

removed without the use of a tool and have also conducted voluntary product recalls to efficiently remove from the marketplace the potentially unsafe products.

Button batteries and consumer products containing button batteries will continue to be actively surveyed as part of a number of ongoing surveillance operations to be conducted by Office of Fair Trading throughout 2016 – 2017, including:

- importers
- safety inspections at the Ekka
- Operation Safe Christmas (annual pre-Christmas toy safety inspection to find and remove unsafe toys from shelves)
- online sales
- market traders.

4. National strategy

On 20 August 2016 the Attorney-General and Minister for Justice and Minister for Training and Skills responded:

On 20 May 2016, the ACCC released a draft of the National Strategy for Improving the Safety of Button Battery Consumer Products 2016-2018. This strategy recognises the need for a nationally consistent approach to improving the safety of products that use button batteries and to reducing the risk of further childhood injuries.

This national strategy, to be conducted over the next two years, will focus on developing evidence to inform regulatory and other approaches to improve button battery safety. It is supported by a series of voluntary industry actions, which will be implemented and monitored for their effectiveness which will include continued education and awareness raising about button battery hazards, as well as direct actions to encourage removal or other mitigation of the risk posed by unsafe button battery products already in retail supply.

The ACCC is leading the strategy with the support of state and territory governments and will be encouraging industry, health agencies and the community to contribute by sharing information, developing product-specific responses and developing an evidence base in a format that will inform and enable future action. The strategy has the following goals:

- increase public awareness of the health risks posed by exposure of children to button batteries
- identify and share best practice in design, supply, use, storage and disposal of button battery consumer products
- improve the identification and risk assessment of button battery products
- identify priority areas where button battery consumer products present a risk, identify the barriers to their safety, including barriers to effective recall, and assess the impacts of necessary improvement
- monitor and promote research into better design, use and disposal of button battery consumer products and treatment of incidents

- adopt a leadership role in securing a consistent international approach to button battery consumer products.

A range of actions at the national level are currently being developed to meet these goals.

On 25 February 2017, the Attorney-General and Minister for Justice and Minister for Training and Skills responded:

The National Strategy for Improving the Safety of Button Battery Consumer Products 2016-2018 progressed during 2016. The main goal of the working party, consisting of the Australian Competition and Consumer Commission and state and territory fair trading agencies, is to ensure a consistent approach is applied to promote awareness and deliver practical and long term solutions set out in the project initiation and implementation plan to reduce the risks posed by button batteries.

A range of initiatives have been developed and approved by the working group and are continuing to be implemented to meet the strategies goals including:

- the development of strategies to facilitate the delivery of the project initiation and implementation plan
- the development of agreed templates for consistent national surveillance activities and reporting
- nationally each jurisdiction has confirmed button battery surveillance would form part of on-going planned surveillance activities
- the development and implementation of centralised reporting protocols for ease of collation and analysis of surveillance data
- the development of agreed urgent national response protocols
- the development of consistent national media and consumer safety education and awareness messaging.

In September 2016, the Australian Competition and Consumer Commission launched the national strategy for improving the safety of button battery consumer products 2016-2018; the Industry code for consumer goods that contain button batteries; and the new button battery DVD, *Button battery safety in the home*. The video aims to give advice on sensible steps to prevent access to button batteries.

While this national action is progressing the Office of Fair Trading continues to remove unsafe products from stores and educate suppliers about how to reduce the risk of supplying unsafe products that contain button batteries.

Recommendation 6a

All state health departments co-ordinate with a view to developing a national reporting system for battery related exposures and injuries.

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:

Queensland Health is meeting with Children's Health Queensland, Poisons Information Centre, Queensland Injury Surveillance Unit, Patient Safety and Quality Improvement Service and Queensland Ambulance Service to identify and agree upon an approach to effectively implement the coroner's recommendations.

More information about the implementation of the recommendation will be provided in mid-2016.

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

The Department of Health and the coroner informed all states and territories of the coroner's recommendations. The Patient Safety and Quality Improvement Service is liaising with nominated state and territory officers to coordinate a Queensland working group to inform the establishment of a national reporting system for disc/button battery related exposures and injuries.

The manager, Poisons Information Centre, Children's Health Queensland Hospital and Health Service met with interstate colleagues at the Toxicology and Poisons Conference in May 2016 to discuss strategies around developing a national reporting system for button battery related exposures.

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

The working group, led by Queensland Health, consulted with representatives from all states and territories resulting in a proposal being submitted to the Australian Paediatric Surveillance Unit (APSU) to develop an online data collection form to enable the collation and analysis of data from serious injuries related to button battery ingestion.

Queensland Health approved funding for a five-year national study to develop the data collection process and conduct the research. This study through the Australian Paediatric Surveillance Unit will survey specialist medical practitioners to readily identify severe battery related exposure and injuries. This information, together with data collected from the Poisons Information Centre, will inform regulatory change as little is known about the associated products, mechanism of access and the outcomes following exposure. This in turn will inform future national reporting requirements.

Recommendation 6b

All state health departments promote Poisons Information Centre services as a first point of information for families following a battery exposure.

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:

Queensland Health is meeting with Children's Health Queensland, Poisons Information Centre, Queensland Injury Surveillance Unit, Patient Safety and Quality Improvement Service and Queensland Ambulance Service to identify and agree upon an approach to effectively implement the coroner's recommendations.

More information about the implementation of the recommendation will be provided in mid-2016.

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

The Department of Health and the coroner informed all state and territories of the coroner's recommendations. The Patient Safety & Quality Improvement Service is liaising with nominated state and territory officers to promote the Poisons Information Centre. The Clinical Excellence

Division provided funding to Kidsafe to develop an awareness campaign around button batteries. This campaign included multiple social media promotions and a poster that was distributed widely to facilities such as child care centres, schools, hospitals and GP practices. The poster directs parents, the public and any services to immediately call the 24 hour Poisons Information Service for advice if a child is suspected of swallowing or inserting a button battery

Recommendation 6c

All state health departments develop retrieval and management protocols for button battery related injuries for their particular jurisdiction. This protocol should be shared with the Poisons Information Centre network.

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:

Queensland Health is meeting with Children's Health Queensland, Poisons Information Centre, Queensland Injury Surveillance Unit, Patient Safety and Quality Improvement Service and Queensland Ambulance Service to identify and agree upon an approach to effectively implement the coroner's recommendations.

More information about the implementation of the recommendation will be provided in mid-2016.

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

The Patient Safety and Quality Improvement Service (PSQIS) is coordinating a working group to develop a retrieval algorithm* (protocol) for suspected or actual battery ingestion.

The algorithm for management of button battery injury has been developed by the Children's Health Queensland Hospital and Health Service (CHQ HHS) and will be hosted on the PSQIS website and distributed statewide, including the Poisons Information Centre network.

An x-ray protocol was drafted by CHQ HHS and is awaiting final approval. Retrieval Services Queensland are being consulted in regard to developing an algorithm for retrieving a child from anywhere in the state to a facility that can manage the child appropriately.

The working group will develop and share all resources with other state and territories and the Poisons Information Centre.

*Algorithm: a simple step-by-step diagram that provides a set of instructions/protocols to assist clinicians to make an appropriate decision.

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

Children's Health Queensland Hospital and Health Service published a work instruction for the triage of patients after ingestion or insertion of disc batteries and a guideline titled *Foreign bodies: Ear, nose, inhaled and ingested emergency management in children*, (that includes an algorithm), on their website for access by all Queensland Health facilities.

The working group developed a draft button battery management protocol for the retrieval of children and have asked for feedback from paediatric specialists within Queensland Health including Retrieval Services Queensland.

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

Further amendment of the retrieval protocol has been required and this was circulated through the broader Queensland Health networks and paediatric specialists for feedback prior to finalisation.

Following endorsement of the button battery management protocol, it will be available on the Children's Health Queensland Hospital and Health Service website and made available to all Queensland Health facilities, the Poisons Information Centre and other states and territories.

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

The retrieval and management protocol and flowchart was endorsed by a wide audience of paediatric specialists and is available on the Children's Health Queensland website to share with clinicians and the Poisons Information Centre.

Recommendation 6d

All state health departments re-design their 24 hour fluid balance charts and introduce protocols to ensure that it is clear where vomit and blood should be recorded, and to standardise the way in which loss of blood is described (in relation to volume, consistency and colour). The form should include the patient's weight and a formula for calculating circulating volume. This form re-design is a broader health issue, not just related to button battery ingestion.

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:

Queensland Health is meeting with Children's Health Queensland, Poisons Information Centre, Queensland Injury Surveillance Unit, Patient Safety and Quality Improvement Service and Queensland Ambulance Service to identify and agree upon an approach to effectively implement the coroner's recommendations.

More information about the implementation of the recommendation will be provided in mid-2016.

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

The Department of Health and the coroner informed all states and territories of the coroner's recommendations. The Patient Safety & Quality Improvement Service is liaising with nominated state and territory officers and Children's Health Queensland Hospital and Health Service to advance the recommendation.

A review of Queensland paediatric fluid balance charts is currently being conducted.

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

The Queensland draft paediatric fluid balance chart and associated protocol were developed and trialled.

The Minister for Health and Minister for Ambulance Services updated:

Following the trial period, the re-designed paediatric 24 hour fluid balance chart was endorsed. The chart was published on the Children's Health Queensland website and is accessible to all Queensland Health facilities.

A statewide advisory group is being established to review the design of adult fluid balance charts currently in use in Queensland Health hospitals.

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

The paper-based version of the paediatric fluid balance chart was shared with all state health departments.

Queensland Health consulted across the state via the paediatric specialty subgroup of the electronic medical record (ieMR) programme and developed changes to the ieMR for both paediatric and adult fluid balance digital records to incorporate the recommendations. The digital fluid balance charts (adult and paediatric) will be standardised across the state with the roll out of the ieMR.

Hospital and health services will be notified of the availability of the paper-based version of the paediatric fluid balance chart and will requested to amend their paper-based versions of the adult fluid balance chart to meet the recommendations of the coroner.

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

The digital fluid balance charts (adult and children) was built into the integrated ieMR and are now in use and compliant with the recommendation. The paper-based version of the children's fluid balance chart is in use at multiple sites and all facilities have been notified to review their paper-based adult chart to comply with the recommendation. The fluid balance charts have provision for entering urine, stool, vomit and other fluid loss (such as blood or wound matter), along with description codes for consistency, colour and odour.

Recommendation 7a

All paediatric hospital sites increase awareness of the identification of button battery ingestion amongst staff, patients and patients' families

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:

Queensland Health is meeting with Children's Health Queensland, Poisons Information Centre, Queensland Injury Surveillance Unit, Patient Safety and Quality Improvement Service and Queensland Ambulance Service to identify and agree on an approach to effectively implement the coroner's recommendations.

More information about the implementation of the recommendation will be provided in mid-2016.

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

The Department of Health met with Children's Health Queensland Hospital and Health Service, Poisons Information Centre, Queensland Injury Surveillance Unit, Patient Safety and Quality Improvement Service (PSQIS) and the Queensland Ambulance Service to identify and agreed on an approach to effectively implement the coroner's recommendations.

The Department and the coroner informed all states and territories of the coroner's recommendations and the PSQIS is liaising with nominated officers from other states and territories.

Queensland Health commenced an awareness campaign in September 2013 to raise staff, patients and family awareness of the identification of disc/button battery ingestion/insertion in children. The PSQIS has published and distributed:

- patient safety communique and an Australian Competition & Consumer Commission poster in September 2013
- patient safety notice with a guide for staff in the use of x-ray to identify disc (button) batteries, February 2014
- poster for clinicians and another for consumers to raise disc/button battery awareness in December 2014
- the Department of Health provided funding to Kidsafe to develop an awareness campaign around button batteries. This campaign included multiple social media promotions and a poster that is being distributed widely to facilities such as child care centres, schools, hospitals and GP practices. The poster directs parents, the public and any services to immediately call the 24 hour Poisons Information Service for advice if a child is suspected of swallowing or inserting a button battery
- to further increase public awareness, several social media campaigns have and continue to be posted to the Queensland Health Facebook page.

Recommendation 7b

All paediatric hospital sites develop algorithms for foreign body related injury and upper gastrointestinal bleeding that highlight the potential involvement of disc batteries. Such algorithms should be accessible externally.

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:

Queensland Health is meeting with Children's Health Queensland, Poisons Information Centre, Queensland Injury Surveillance Unit, Patient Safety and Quality Improvement Service and Queensland Ambulance Service to identify and agree on an approach to effectively implement the coroner's recommendations.

More information about the implementation of the recommendation will be provided in mid-2016.

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

The Department of Health and the coroner informed all states and territories of the coroner's recommendations. The Patient Safety and Quality Improvement Service is liaising with nominated state and territory officers and informed of Queensland Health's plan to develop and share all resources (algorithms) with other state and territories once they are developed.

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

The button battery flow chart (algorithm) for foreign body related injury and upper gastrointestinal bleeding that highlights the potential involvement of disc batteries was drafted and circulated within Queensland Health for comment.

The Minister for Health and Minister for Ambulance Services updated:

The Children's Health Queensland Hospital and Health Service developed the guideline titled *Foreign*

bodies: ear, nose, inhaled and ingested emergency management in children. The guideline includes flow charts for foreign bodies, specifically for button/disc batteries that occur in the upper gastrointestinal tract and stomach (as discussed in the earlier implementation update, above).

The guideline was published on the Queensland Health electronic publishing system and is accessible to all Queensland Health hospitals.

Recommendation 9

The Australian Health Practitioner Regulation Agency raise awareness amongst clinicians, pharmacists, and radiographers in relation to emerging product safety issues such as button battery ingestion by emailing a brief description of the issue and providing a link to the Australian Competition and Consumer Commission reporting site and the Poisons Information Centre.

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:

The Department of Health wrote to the Australian Health Practitioner Regulation Agency (AHPRA) requesting the agency to action the coroner's recommendation.

More information about the implementation of the recommendation will be provided in mid-2016.

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

AHPRA worked with national boards (see below) to increase awareness as requested by the coroner.

The work includes: publishing the findings and coroner's recommendations on the AHPRA website, and social media posts (AHPRA Facebook and Twitter) with a video link to the Australian Competition & Consumer Commission.

In addition, AHPRA provided an article to raise awareness about button batteries for inclusion in the following board newsletters: Medical; Aboriginal and Torres Strait Islander Health Practice Board; Nursing and Midwifery; Pharmacy; and Medical Radiation Practice.

Recommendation 11a

The Nambour General Hospital implement a protocol to ensure that where the Nambour General Hospital provides primary support to other hospitals (such as paediatric support to the Noosa Private Hospital), information is sought and advice provided in a structured and standardized manner (to minimise the risk of misdiagnosis and mismanagement).

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:

The Department of Health wrote to Nambour General Hospital requesting the hospital service to action the coroner's recommendation.

More information about the implementation of the recommendation will be provided in mid-2016.

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

A principal house officer telephone record handover template is partially developed by the Department of Paediatrics to facilitate advice being provided and received in the structured Identify, Situation, Background, Assessment and Recommendation (ISBAR) format. It is now undergoing validation.

The telephone record handover template will be finalised in 2016 with documented criteria/indications for use. It will be trialled first within the Department of Paediatrics and is planned to be subsequently developed into an online document which will ultimately be able to be stored in a clinical record, if the patient has a record at the Sunshine Coast Hospital and Health Service.

The processes for utilisation of the telephone record handover template will be communicated to new and existing medical staff in an induction manual and through a local poster awareness campaign, highlighting practice change.

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

To assist clinicians communicate information in regards to patient care, the Sunshine Coast Hospital and Health Service—which includes Nambour General Hospital—has a clinical handover procedure that provides a structured and standardised way in which to facilitate care of patients through timely, relevant and structured transfer of information and accountability.

The paediatric clinical telephone advice record was specifically developed to use when telephone advice is provided by the Sunshine Coast Hospital and Health Service paediatric department.

The Minister for Health and Minister for Ambulance Services updated:

The revised paediatric clinical telephone advice record template was published on the Queensland Health Electronic Publishing Service (QHEPS) in May 2017. Education and awareness raising on how to use the revised form was delivered to the doctors within the Sunshine Coast Hospital and Health Service. This form will guide the manner in which advice is given by medical practitioners to other care providers outside of the hospital and health service.

Recommendation 11b

The Nambour General Hospital implement a protocol to ensure that where the Nambour General Hospital provides primary support to other hospitals (such as paediatric support to the Noosa Private Hospital), the advice is recorded by the medical practitioner providing the advice, regardless of whether the Nambour General Hospital holds a patient file for the patient being discussed.

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:

The Department of Health wrote to Nambour General Hospital requesting the hospital service to action the coroner's recommendation.

More information about the implementation of the recommendation will be provided in mid-2016.

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

A principal house officer telephone record handover template has been partially developed by the Department of Paediatrics.

The telephone record handover template will be finalised in 2016. When the online record is developed, it will be able to be stored in a clinical record, when the advice pertains to a patient who has been, or is being admitted to the Sunshine Coast Hospital and Health Service.

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

To assist clinicians communicate information in regards to patient care, the Sunshine Coast Hospital and Health Service—which includes Nambour General Hospital—has a clinical handover procedure that provides a structured and standardised way in which to facilitate care of patients through timely, relevant and structured transfer of information and accountability.

The paediatric clinical telephone advice record template for use by medical staff was drafted. Strategies are being developed to ensure telephone records are retained and filed to support handover processes in an effective manner.

The Minister for Health and Minister for Ambulance Services updated:

Sunshine Coast Hospital and Health Service developed a protocol where medical practitioners record advice to other care providers outside of the hospital and health service. As part of this protocol the paediatric clinical telephone advice record is required to be completed as per recommendation 11a above. The record can be completed regardless of whether the patient is an inpatient.

Recommendation 12

The Queensland Ambulance Service develop procedures and training to enable ambulance officers who attend a scene and have an opportunity to observe blood to more accurately record colour, consistency and volume (where clinical circumstances allow).

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:

The Queensland Ambulance Service is considering this recommendation. More information about whether the recommendation will be supported will be provided in mid-2016.

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

The *Disc battery clinical practice guide* CPG provides all Queensland Ambulance Service staff with clear guidance in the recognition of possible ingestion and the appropriate management.

The *Hypovolaemic shock clinical practice guide* is updated to include the statement ‘pre-hospital measurement of external blood loss is inherently inaccurate, however an indicative estimate must be recorded on the electronic Ambulance Report Form (eARF) to aid patient care considerations’. Specific content is included in a statewide education package to complement the release of a suite of requirements within the Queensland Ambulance Service *Digital clinical practice manual*.