

Inquest into the death of Ryan Charles Saunders

Ryan Saunders died on 26 September 2007 at Rockhampton Base Hospital from toxic shock syndrome precipitated by a Group A Streptococcal infection which probably originated in his throat. Ryan's condition deteriorated after those treating him at the Rockhampton Base Hospital failed to detect and respond to the infection in a sufficiently timely manner. Ryan was nearly three years old when he died.

State Coroner Michael Barnes delivered his findings of inquest on 7 October 2011.

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.

Comments, page 28-30

When considering what improvements might be recommended as a result of the events leading to Ryan's death I have benefited from having regard to the 16 recommendations made by the Health Quality and Complaints Commission (HQCC). Although most of them would not have resulted in a different outcome for Ryan, I am satisfied each of them is an appropriate response to the problematic systemic issues brought into focus by Ryan's case.

Dr John Wakefield, the Director of the Queensland Health and Patient Safety and Quality Improvement Service told the inquest that 13 of the 16 recommendations had been implemented in full. Dr Wakefield gave evidence that the remaining three recommendations are very close to finalisation. Those recommendations are numbers 3, 7 and 8.

HQCC recommendation three –Queensland Health to advise when the forced CRP (C-reactive protein) reporting tool has been implemented statewide.

HQCC recommendation seven –Queensland Health consider developing and implementing an early warning observation system for use in all Queensland Health paediatric facilities and by the Paediatric Emergency Team.

HQCC recommendation eight –Queensland Health implement an escalation procedure for pathology reports and consider the merits of an automated pathology alert system which automatically signals and notifies the relevant clinician of any significant variance in results.

Recommendations three and eight are near completion and will seemingly result in best practice when it comes to the way in which doctors in Queensland hospitals order pathology tests and how they are notified of critical pathology results.

Recommendation seven could in fact be said to have been fulfilled as the department has in fact developed such a system - the Children's Early Warning Tool (CEWT) - and has trialled it in a number of hospitals including Rockhampton... I am satisfied that the research and effort put into the development of the CEWT system is a satisfactory response.

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:

Recommendation three, implementation of a state-wide reporting tool for the forced CRP (C-reactive protein) is planned to be delivered as part of a medical record system that will include the ability for doctors to order pathology and radiology tests using a computer rather than handwritten on paper. This part of the medical record system is planned to be rolled out to other sites. In the short term, rollout of the medical record system will be limited to a small number of public hospitals however the department is committed to implementing electronic medical record systems to the rest of the state over a number of years.

Recommendation seven, a children's early warning tool (CEWT), was implemented in 2010. The tool allows an overall illness-severity score to be calculated from the child's observations and alerts clinicians that the child's condition may be deteriorating.

Recommendation eight is also implemented. All QH clinicians currently have access to the QH laboratory information system which currently provides real time result reports as soon as they are available.

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

Queensland Health confirms that the implementation of recommendation three, the forced CRP (C-reactive protein) reporting tool has been available statewide since 2012, when AUSCARE was made available across all hospital and health services. AUSCARE is the statewide, web based browser available to clinicians to review and endorse pathology results. AUSCARE supports clinical practice and provides enabling support for the reporting of CRP (C-reactive protein) diagnostic tests statewide.

In addition, to the coroner's recommendation, Queensland Health is introducing a new digital hospital system as part of its ieMR program which will implement patient electronic medical records that will enable clinicians to order pathology and radiology tests using a computer, rather than handwritten orders using paper request slips. Implementation of this new system commenced in November 2015 and will be rolled out to more sites over a number of years.