health quality and complaints commission

POSITIVE HEALTH ACTION

Report of the Health Quality and Complaints Commission

Public Report:

An investigation into the quality of health services in the Cherbourg Aboriginal Community.

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An investigation into the quality of health services in the Cherbourg Aboriginal Community

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Contents

Executive Summary

1. This is the public report of an investigation by the Health Quality and Complaints Commission (HQCC) into the quality of health services in the Cherbourg Aboriginal Community which was conducted at the direction of the Honourable Stephen Robertson MP, Minister for Health, under sections 86(f) and 164(1)(e) of the *Health Quality and Complaints Commission Act 2006* (Qld).

2. The final investigation examined a large amount of personal and private medical information, and to protect the privacy of those concerned, this abridged and de-identified report has been prepared for release to the public.

3. The investigation arose from concerns raised by the Cherbourg Aboriginal Shire Council about the interaction between the Cherbourg Hospital and the Cherbourg community, and the deaths of

   - Ms Maureen Weazel at Cherbourg on 8 July 2006;
   - Ms Dawn Chambers at Cherbourg on 10 July 2006; and
   - Mr Raymond Edwards at Toowoomba on 24 July 2006.

Scope

4. The role of the HQCC is to monitor, review and report on the quality of health services, recommend action to improve the quality of health services, help users and providers resolve health service complaints, and preserve and promote health rights.

5. It is not the role of the HQCC to apportion fault, blame or culpability.

6. In this context, this report contains information, comment, opinions and recommendations for action which the HQCC consider appropriate.

Background

7. The Cherbourg Aboriginal community has a permanent population of around 1,250. The main tribal group is the Wakka Wakka people. Cherbourg is located 6 kilometres from Murgon, but the Cherbourg Aboriginal Shire Council is an independent local government authority, separate from Murgon Shire.

8. Health services in Cherbourg are provided by:

   (a) The Cherbourg Rural Health Service, operated by Queensland Health (including the Cherbourg Hospital and the Cherbourg Community Health Service);

   (b) The Ny-Ku Byun Hostel, an accredited 20 bed aged care facility operated by the Cherbourg Aboriginal Shire Council, which provides aged care and respite services to the Cherbourg community; and

   (c) The Barambah Regional Medical Service, a community controlled organisation largely funded by the Australian Government to provide health services to the Cherbourg Aboriginal community and the wider non-indigenous community in the South Burnett.

Death of Maureen Weazel, aged 25 years

9. Some time prior to 4:00am on 8 July 2006, Ms Maureen Weazel (aged 25 years) was in a car with Mr Henry Gyemore when she suffered a heart attack and became unconscious. Mr Gyemore drove Ms Weazel to the Cherbourg Hospital seeking emergency medical treatment.

10. It is alleged Mr Gyemore was unreasonably refused access to the Cherbourg Hospital, and was left outside the hospital for 90 minutes to two hours, before police arrived and found Ms Weazel in Mr Gyemore's car. Hospital staff attempted resuscitation, but Ms Weazel was declared dead at 4:30am.

11. The investigation into the circumstances surrounding the death of Ms Weazel focused on three principal issues:

    - Was Mr Gyemore left outside the Cherbourg Hospital without medical assistance for "*an hour and a half, or two hours"?*
    - Were there reasonable grounds for staff to refuse Mr Gyemore entry to Cherbourg Hospital?
    - Could the death of Ms Weazel have been prevented with more appropriate treatment or safeguards?

12. The investigation found:

    (i) There is reliable and independent evidence beyond any reasonable doubt that Mr Gyemore arrived with Ms Weazel at the Cherbourg Hospital at 3:55am, police were called immediately and arrived at the hospital at 4:05am, and Ms Weazel was taken into the hospital at 4:08am.

    (ii) The nursing staff of Cherbourg Hospital had an honest and reasonable, but mistaken, belief that Mr Gyemore was a present and immediate threat to their personal safety and the safety of inpatients at the Cherbourg Hospital, and it was reasonable for the nurses to refuse Mr Gyemore entry to the Cherbourg Hospital until police arrived.

    (iii) An inoperable audio intercom at the emergency entrance of the Cherbourg Hospital prevented effective verbal communication with Mr Gyemore, and contributed to the nurses' misunderstanding of Mr Gyemore's obvious distress and the actual emergency situation.

    (iv) It is not likely Ms Weazel would have survived neurologically intact even if the nursing staff had commenced basic life support immediately on Mr Gyemore's arrival.

    (v) South Burnett Health Service District has taken appropriate remedial action to prevent a similar recurrence of this incident.

13. Australian Standard AS 4485 'Security for health care facilities' sets out requirements for health care facilities in developing policy, principles and procedures for the protection of patients, staff and others who are required to work at or attend such a facility.

14. The South Burnett Health Service District has a security policy and procedures that are consistent with Australian Standard AS 4485. The actions of nursing staff in refusing Mr Gyemore entry to the Cherbourg Hospital was consistent with that policy, but

recommended communication strategies were not effected with Mr Gyemore. This can reasonably be attributed to the difficulty hearing Mr Gyemore through the two sets of closed doors and because the intercom was inoperable.

15. Recommendations (Death of Maureen Weazel)

I. That Queensland Health implement the findings of the root cause analysis into the circumstances surrounding the death of Ms Maureen Weazel, in particular:

(i) Undertake a daily check of the correct functioning of the security intercom;

(ii) Provide nursing staff with orientation and training in the security camera equipment;

(iii) Develop a formalised system/tool for reporting equipment defects, maintenance requirements and repairs; and

(iv) Review the compliance of Cherbourg Hospital with the Australian Standard AS 4485 *'Security for health care facilities'*.

II. That Queensland Health draws no adverse inference about the conduct of staff at Cherbourg Hospital in refusing Mr Gyemore entry to the hospital until police arrived.

III. That Queensland Health consult with the Department of Tourism, Fair Trading and Wine Industry Development about exemptions for security provider licensing to permit members of the Cherbourg Community to provide security services at Cherbourg Hospital.

Death of Dawn Chambers, aged 60 years

16. About 2:00pm on 10 July 2006, Mrs Dawn Chambers presented to Cherbourg Hospital because she was out of medication for her long standing condition of heart failure. Mrs Chambers was reviewed by a medical officer and an x-ray was ordered.

17. At the time, the x-ray at Cherbourg Hospital was unserviceable, and Mrs Chambers was referred to Murgon Hospital for the x-ray. Mrs Chambers did not have personal transport, so Mrs Chambers walked down the street and got a lift (from a passing motorist) to Murgon Hospital, where the x-ray was taken by a qualified nurse.

18. Mrs Chambers was unable to organise transport back to Cherbourg Hospital to have the x-ray reviewed later that afternoon.

19. At about 6:00pm that evening, Mrs Chambers returned to her daughter's house in Cherbourg. Mrs Chambers died at 7:52pm from a cardiac arrest.

20. It is alleged Mrs Chambers death could have been prevented if the Cherbourg Hospital had provided transport for Mrs Chambers to Murgon Hospital to have the x-rays taken, and back to Cherbourg Hospital to have the x-rays reviewed.

21. The investigation into the circumstances surrounding the death of Ms Chambers focused on three principal issues:

- Was the death of Mrs Dawn Chambers foreseeable when she attended Cherbourg Hospital?
- Could the death of Mrs Chambers have been prevented with more appropriate treatment or safeguards?
- Should Mrs Chambers have been assisted with, or provided transport to Murgon Hospital?

22. The investigation found:

(i) The death of Mrs Chambers was not reasonably foreseeable by the treating doctor at Cherbourg Hospital ('the treating doctor").

(ii) It is unlikely the death of Mrs Chambers could have been prevented even if transport to Murgon had been provided.

(iii) It would have been reasonable to assist Mrs Chambers with transport to Murgon Hospital, but this was contrary to hospital policy.

(iv) The treating doctor had commenced relieving duties at Cherbourg Hospital without an appropriate understanding of the cultural environment and special needs of the Cherbourg Aboriginal Community, and in particular that a patient such as Mrs Chambers would have to hitch hike to Murgon Hospital to access x-ray facilities.

(v) The internal investigation by the South Burnett Health Service District has not addressed the appropriateness of the District policy prohibiting any outpatient transport.

(vi) The policy of prohibiting any outpatient transport is not consistent with the purpose and intent of the *Cultural Respect Framework For Aboriginal And Torres Strait Islander Health 2004 – 2009* and Queensland Health's *Directions for Aged Care 2004-2011*.

23. Recommendations (Death of Dawn Chambers)

I. That Queensland Health review the root cause analysis into the circumstances surrounding the death of Mrs Dawn Chambers, taking into account the evidence of the treating doctor.

II. That Queensland Health review the policy in the South Burnett Health Service District (and elsewhere in Queensland) which prohibits the transport of outpatients in Queensland Health vehicles.

III. That Queensland Health, in consultation with the Cherbourg Aboriginal Community, develop and implement cultural awareness training at Cherbourg Hospital to improve staff knowledge and awareness about the physical, spiritual, cultural, emotional and social aspects of the Cherbourg Aboriginal Community.

IV. That Queensland Health draws no adverse inference about the conduct of the treating doctor and the treatment of Mrs Dawn Chambers at Cherbourg Hospital.

Death of Raymond Edwards, aged 65 years

24. Mr Raymond Edwards was a long term resident of Ny-Ku Byun Aged Care Hostel, Cherbourg.

25. On 21 June 2006, Mr Edwards had a fall at the Ny-Ku Byun Hostel and was taken to Cherbourg Hospital with multiple injuries. The x-ray equipment at Cherbourg was unserviceable, and Mr Edwards was transferred to Toowoomba Base Hospital. A fractured patella (kneecap) was diagnosed, and a long leg plaster cast was applied.

26. On 28 June 2006, Mr Edwards was transferred back to Cherbourg Hospital, and on 7 July 2006, Mr Edwards was discharged from Cherbourg Hospital back to the Ny-Ku Byun Hostel.

27. On 11 July 2006, Mr Edwards was readmitted to Cherbourg Hospital with pressure sores on his thigh around the long leg plaster cast. On 17 July 2006, Mr Edwards was discharged from Cherbourg Hospital back to Ny-Ku Byun Hostel.

28. At about 3:50am on 24 July 2006, Mr Edwards was admitted to Cherbourg Hospital with severe abdominal pain. Mr Edwards deteriorated during the day showing signs of being in shock.

29. At about 6:00pm on 24 July 2006, Mr Edwards was transferred by emergency Care Flight to Toowoomba Hospital. Mr Edwards was diagnosed with multiple medical co-morbidities and a decision was made by the consultant surgeon and anaesthetist that Mr Edwards was not suitable for surgical intervention. Mr Edwards died at 7:30pm.

30. It is alleged Mr Edwards died from a ruptured bowel as a result of constipation, and the constipation was the result of repeated administration of Panadeine Forte prescribed by Cherbourg Hospital. It is further alleged that the Cherbourg Hospital failed to prescribe Coloxyl with Senna on Mr Edwards discharge from hospital to prevent constipation.

31. The investigation into the circumstances surrounding the death of Mr Edwards focused on three principal issues:

    - Did Mr Edwards die from a perforated bowel due to, or as a consequence of, constipation?
    - Could the death have been prevented with more appropriate treatment or safeguards?
    - Is there consistent continuity of care between the Cherbourg Hospital and the Ny-Ku Byun Hostel?

32. The investigation found:

    (i) Mr Edwards did not die from a perforated bowel due to, or as a consequence of, constipation.

    (ii) There is conclusive evidence that Mr Edwards died of an ischemic bowel caused by underlying arterial disease.

    (iii) The death of Mr Edwards could not have been prevented.

(iv) There was not consistent continuity of care between the Cherbourg Hospital and the Ny-Ku Byun Hostel.

33. Recommendations (Death of Raymond Edwards)

I. That Queensland Health draws no adverse inference about the conduct of staff at Cherbourg Hospital in the treatment of Mr Raymond Edwards.

II. That Queensland Health consult with the Cherbourg Aboriginal Shire Council and Barambah Regional medical Service to improve communication between the Cherbourg Hospital and Ny-Ku Byun Hostel and improve the continuity of care and transfer of information when residents are admitted to, and discharged from, hospital.

III. That Queensland Health review the operations of Cherbourg Hospital to ensure they are consistent with the purpose and intent of the *Cultural Respect Framework For Aboriginal And Torres Strait Islander Health 2004 – 2009* and Queensland Health's *Directions for Aged Care 2004-2011* with particular attention to:

(i) Supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context;

(ii) Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way;

(iii) Linking clinical treatment and continuity of care that spans community, hospital and residential aged care facilities;

(iv) Discharge planning to residential aged care facilities with particular focus on wound management, medication management and continence care;

(v) The appropriateness of referring community residents receiving complex post-acute care (such as complex wound care, complex pain management and dialysis treatment) to the 13HEALTH telephone service; and

(vi) Preventing the premature discharge from hospital of high care residents requiring complex post-acute care.

1. Introduction

On 1 August 2006, representatives of the Cherbourg Aboriginal Shire Council and the Cherbourg Aboriginal Community met with the Honourable Stephen Robertson MP, Minister for Health, and expressed concerns about the deaths of:

- Ms Maureen Weazel at Cherbourg on 8 July 2006;
- Ms Dawn Chambers at Cherbourg on 10 July 2006; and
- Mr Raymond Edwards at Toowoomba on 24 July 2006.

The representatives informed the Minister that the circumstances in which these deaths occurred raised issues about the interaction between the Cherbourg Hospital and Cherbourg Community, as well as other local services, such as the Barambah Regional Medical Service and the Ny-Ku Byun aged care hostel.

As a result, the Minister directed the Health Quality and Complaints Commission (HQCC) to investigate the provision of health services to the Cherbourg Aboriginal Community under sections 86(f) and 164(1)(e) of the *Health Quality and Complaints Commission Act 2006* (Qld).

The role of the Commission is to monitor, review and report on the quality of health services, recommend action to improve the quality of health services, help users and providers resolve health service complaints, and preserve and promote health rights. It is not the role of the Commission to apportion fault, blame or culpability. In this context, this report contains information, comment, opinions and recommendations for action which the Commission consider appropriate.

The Commission extends its sincere condolences to the Cherbourg Aboriginal Community, and in particular the families of Ms Maureen Weasel, Ms Dawn Chambers and Mr Raymond Edwards for the loss of their loved ones.

The Commission acknowledges the co-operation and support of the management and staff of the South Burnett Health Services District and the Ny-Ku Byun Hostel, in this investigation. Despite the criticisms levelled at some members of the medical and nursing staff, their willingness to address the community's concerns and improve the quality of health services remained paramount.

2. The Cherbourg Aboriginal Community

The Cherbourg Aboriginal Community has a permanent population of around 1,250, of which approximately 97 per cent are of Aboriginal or Torres Strait Islander origin. The main tribal group is the Wakka Wakka people (who originally lived in the area between Dalby and Maidenwell).

Although Cherbourg is located 6.24 kilometres from Murgon, the Cherbourg Aboriginal Shire Council is an independent local government authority, separate from Murgon Shire.

3. The Health Services In Cherbourg

3.1 Cherbourg Rural Health Service (Queensland Health)

The Cherbourg Rural Health Service is operated by Queensland Health in the South Burnett Health Services District and includes the following services:

Hospital	Accident and Emergency; General Wards; Community Midwife Program; Paediatrics; Diabetics and Nutrition Program; Alcohol and Drug Program; Immunisation.
Specialist Services	Visiting Paediatrician (1 day per month); Ear, Nose and Throat Clinic (2 days per year); Thoracic Team (1 day per month)
Clinics Available	Outpatients; Women's Health; Special Medical; Well Baby; Immunisation; Eye
Allied Health Services	Visiting Speech Pathologist (as needed); Physiotherapist (weekly); Occupational Therapist (as needed)
Outreach Services	Child Health Clinic and Community Health Nurse; Dental; Sexual Health; Mens Health; Renal Follow up; Post Discharge
Community Health Services	Child Health; Nutrition & Diabetics; Environmental Health; Sexual Health; Health Promotion; Drug & Alcohol; Mental Health; Social Work; Inter District Services; Exercise Classes

http://www.health.qld.gov.au/services/facilities/sburn_cbourg_rhs.asp

3.2 Ny-Ku Byun Hostel

The Ny-Ku Byun Hostel is an accredited 20 bed aged care facility operated by the Cherbourg Aboriginal Shire Council, an Approved Provider under the *Aged Care Act 1997* (Cwth). The hostel provides aged care and respite services to Aboriginal & Torres Strait Islander clients in the Cherbourg community.

The Ny-Ku Byun Hostel is accredited by the Aged Care Standards and Accreditation Agency to 3 October 2008.

The Ny-Ku Byun Hostel provides both high level care and low level care which allows residents to 'age in place' (meaning the residents can stay in the hostel as their care needs increase). As at 20 December 2006, there were 14 high care residents in the Ny-Ku Byun Hostel.

Low-level care provides accommodation, support services (cleaning, laundry and meals), personal care services (help with dressing, eating, toileting, bathing and moving around), and may provide or have access to some allied health services (such as physiotherapy, occupational therapy, recreational therapy and podiatry).

High-level care involves 24 hour care. Nursing care is combined with accommodation, support services (cleaning, laundry and meals), personal care services (help with dressing, eating, toileting, bathing and moving around) and

allied health services (such as physiotherapy, occupational therapy, recreational therapy and podiatry).

Only an Approved Provider is entitled to receive Australian Government funding for aged care including the allocation of places. In return, the Approved Provider is responsible for meeting conditions of approval and the range of requirements and responsibilities relating to standards of care and protections for residents.

An Approved Provider can contract with someone else to undertake some, or many, of the tasks required in operating the service. Even in this case it is still the Approved Provider who retains responsibility and the funding entitlement.

The Department of Health and Ageing, which regulates aged care providers funded by the Australian Government, imposes sanctions on the Approved Provider if statutory conditions of approval are not met.

3.3 Barambah Regional Medical Service

The Barambah Regional Medical Service is a community controlled organisation which was established in 2001 to provide health services to the Cherbourg Aboriginal community and the wider non-indigenous community in the South Burnett.

This service provides general practice clinics and is largely funded by the Australian Government, Office for Aboriginal and Torres Strait Islander Health. The main clinic is in Cherbourg, and outreach services are provided in Mundubbera, Nanango and Kingaroy.

The Barambah Regional Medical Service employs two doctors, one registered nurse and three aboriginal health workers. Community primary health care is provided by four aboriginal health workers and a counsellor.

4. Death of Maureen Weazel, aged 25 years

4.1 Background

In the early morning hours before 3:55am on 8 July 2006, Ms Maureen Weazel (aged 25 years) was in a car with Mr Henry Gyemore when she suffered a heart attack and became unconscious. Mr Gyemore drove Ms Weazel to the Cherbourg Hospital seeking emergency medical treatment, but was initially refused entry to the hospital. Ms Weazel died.

On 12 July 2006, the incident was reported by Mr Tony Koch in *The Australian*. This newspaper article reflects the general concerns expressed by various members of the Cherbourg Community about the circumstances surrounding Ms Weazel's death.

Woman dies in car outside hospital

An Aboriginal woman celebrating her 25th birthday has died outside a Queensland hospital after nurses tragically mistook her distraught friend for a violent drunk.

Maureen Weazel had spent Friday night dancing and singing at her party in Cherbourg, west of Gympie, with friends and family. But she died of an apparent heart attack the next morning as a friend, Henry Gyemori, tried in vain for 90 minutes to have medical staff come outside the hospital to help her.

``The nurse was standing there looking at me and she signalled for me to go away,'' Mr Henry told The Australian yesterday."

He had left the party with Ms Weazel to go driving."

``I was panicking because I was checking on Maureen and she was on the back seat of the car and not moving, but I could not get them to open the door."

``I was yelling and kicking the door, and head-butting it."

``I could see nurses inside, and there was a security bloke sitting there as well, but nobody came."

``After an hour and a half, or two hours, the cops arrived and they called out to me to settle down because I was going off my head. I had torn a steel railing off and was bashing the door. And when they realised the problem, Maureen was taken inside. I had been checking on her, telling her not to worry because we were at the hospital."

``I done my best.''

Police are preparing a report on Ms Weazel's death for the Coroner. A Queensland Health spokeswoman would not comment yesterday but sources confirmed the tragedy behind the death.

Maureen's younger sister, Amber, travelled 1000km from Mt Isa to attend the birthday bash. Yesterday, she was distraught at what had happened -- and facing waiting until Monday to bury her sister.

``Maureen had sugar diabetes, and so did Mum, who died when she was 34, and us girls were aged 12 and 13," Amber said.

``That is why we were close. It seems unbelievable that somebody so full of life at a party could be dead just hours later -- after getting to the hospital."

``They need a loudspeaker outside the hospital so people are not just left standing there and nurses look out to see who it is."

``This is supposed to be an emergency part of the hospital."

``We have been told by other people inside that night that one young girl was in there after a domestic violence incident and she was saying, `Don't open up -- it's my man come to get me'."

``My sister was in the car all the time, unconscious."

Cherbourg Mayor Ken Bone said it was a tragedy that had victims on the family side as well as from the hospital.

``I can see both sides in this, but it something that never should have happened," Mr Bone said. ``The nurse was too scared to open up."

``We had a meeting yesterday with Health department officials, our council and police."

``We said better lighting and an intercom system were needed, and security staff at the hospital had to be employed past midnight, and it had to be a local bloke -- not some white guy who does not know anybody."

4.2 Scope of investigation

The investigation into the circumstances surrounding the death of Ms Weazel focused on three principal issues:

1. Were there reasonable grounds for staff to refuse Mr Gyemore entry to Cherbourg Hospital?
2. Was Mr Gyemore left outside the Cherbourg Hospital without medical assistance for "*an hour and a half, or two hours"?*
3. Could the death of Ms Weazel have been prevented with more appropriate treatment or safeguards?

4.3 Investigation process

In the investigation interviews were conducted with relevant medical and nursing staff at Cherbourg Hospital, Mr Henry Gyemore and the family of the deceased.

Documentary evidence reviewed included medical records of the deceased, media clippings, coronial investigation documents and witness statements, Qld Health internal investigation documents and standards and policies relevant to hospital security.

CCTV video footage was reviewed indicating the time of Mr Gyemore's arrival at the hospital and his presentation, arrival of police and the time that Ms Weasel was admitted into the hospital for treatment.

The CCTV is movement activated and only records when movement is detected. The CCTV records black and white images, the time and date, but there is no sound recording.

The CCTV security video recordings provided objective evidence of the time of Mr Gyemore's arrival at the hospital, his presentation and sequence of events including the arrival of the police and the admission of Ms Weazel to the hospital.

4.4 Relevant standards, policies and procedures

Australian Standard AS 4485 'Security for health care facilities' sets out requirements for health care facilities in developing policy, principles and procedures for the protection of:

(a) patients, staff and others who are required to work at or attend such a facility;

(b) drugs, other controlled substances, and other dangerous goods;

(c) information; and

(d) other property, including money, owned by, or in the control of, the facility, and the property of patients, staff and others at the facility.

Part 1 sets out the essential requirements needed to provide a safe and secure environment for staff, patients and visitors in health care facilities. Part 2 is a comprehensive guide to the implementation of security services. Both documents cover facilities ranging from major hospitals to small, remote outposts, but each facility needs to undertake the security risk assessment process to produce a program suited to each facility's particular requirements and environment.

The South Burnett Health Service District has security policy and procedures (Appendices 35 & 36) that are consistent with the Australian Standard AS 4485.

The actions of nursing staff in refusing Mr Gyemore entry to the Cherbourg Hospital were essentially consistent with that policy, but recommended communication strategies were not effected with Mr Gyemore. This can reasonably be attributed to the difficulty hearing Mr Gyemore through the two sets of closed doors and because the intercom was inoperable.

4.5 Root cause analysis

Queensland Health conducted an internal investigation into the incident and provided the HQCC with a copy of recommendations made following the Queensland Health investigation.

4.6 Discussion

After hours hospital access

The investigation has identified at least seven people who were promptly allowed entry via the emergency entrance of the Cherbourg Hospital between 2:00am and 3:00am on 8 July 2006. These people attended with two emergency outpatients and were allowed to enter the hospital promptly after pressing the door buzzer.

This demonstrates the nurses' willingness to accept emergency outpatients just before the attendance of Henry Gyemore. There is no evidence that after hours emergency access to the hospital is unduly restricted.

Threat level

The CCTV recording confirms that Henry Gyemore first arrived at the Cherbourg Hospital at approximately 3:55am.

The nursing staff made the first '000' call at approximately 3:59 am, and the '000' call confirms the nurses' state of mind that Mr Gyemore was perceived as a threat.

The second '000' call at 4:05am confirms the nurses' state of mind that the perceived threat by Mr Gyemore was escalating.

There is no evidence that the nurses ignored Mr Gyemore, but in compliance with hospital policy and procedures were seeking police assistance before approaching Mr Gyemore. With no security provider present, this limited the nurses' options to protect their, and the patients, personal safety.

The CCTV recording confirms that Mr Gyemore was outside the hospital for a maximum of 10 minutes before police arrived and a further three minutes passed before Ms Weazel was taken inside the hospital.

The CCTV recording does not include an audio recording, but the physical actions of Mr Gyemore demonstrate his escalating frustration at being refused entry, and could reasonably have been interpreted as a threat by the nursing staff.

Security providers

The after hours safety risks at the Cherbourg Hospital are well known given the widespread abuse and misuse of alcohol and drugs in the community. Because most incidents occur before midnight, a private contractor security provider is currently employed until midnight. There is no security provider after midnight.

Local Councilors report difficulties sourcing licensed security providers to work in Cherbourg and as a result, only limited security services are available at the hospital. The Councilors indicated there were a number of Cherbourg Community members who had undertaken training to be security providers, but were unable to work because of strict licensing requirements.

The HQCC is aware that the Department of Tourism, Fair Trading and Wine Industry Development (DTFTWID), which regulates security providers under the *Security Providers Act 1993*, has granted certain licensing exemptions to security providers in remote Cape York Indigenous communities where there is a limited pool of licensed security providers and access to culturally appropriate security services is almost non-existent. Strict controls apply.

The situation in Cherbourg should be referred to the Director General of DTFTWID to consider whether licensing exemptions are appropriate for the provision of security services at Cherbourg Hospital.

Other significant issues

The situation was exacerbated because there are two sealed doorways from the outside of the hospital to the nurses' station. This severely restricts direct audibility of external voices. Although the buzzer at the emergency entrance was working, the two way audio intercom to the nurses' station was not working.

The Director of Nursing advised that the audio intercom had been inoperable for several months. The exact time during which the intercom was not operating is unknown, but there is said to be frustration with regular acts of vandalism to external fixtures and fittings of the hospital.

The situation was further exacerbated because the nurses did not approach the front entrance as a lock on the second set of entry doors was said to be defective. This impeded the nurses' external view and their ability to hear what Mr Gyemore was saying. In addition, the nursing staff had not been trained on changing CCTV camera modes to improve their field of view.

It was also identified that due to high staff turnover, the nursing staff had limited local knowledge and cultural awareness, and this may have contributed to the incident.

Was the death preventable?

At autopsy the cause of death was identified as severe coronary atherosclerosis.

Coronary Atherosclerosis

Myocardial infarction (MI), or heart attack, occurs when damage to the heart muscle results from interrupted blood flow to the tissue. Most commonly, a heart attack is the direct consequence of coronary atherosclerosis, or hardening of the arteries. The blocked arteries stop blood flow to the heart tissue and deprive the heart cells of necessary oxygen. If large areas of the heart are deprived of oxygen, the heart may beat irregularly or even stop beating altogether.

Other significant findings at autopsy included cirrhosis of the liver.

Cirrhosis of the liver

Cirrhosis of the liver happens when the cells of the liver are damaged by toxins, or by inflammation and disorders of the body's normal metabolic processes. Progressive scarring (fibrosis) of the liver causes scar tissue to replace normal liver tissue. The scar tissue damages the normal structure of the liver which affects the normal flow of blood through the liver. The liver itself becomes distorted, hardened and lumpy. Without a good blood flow the liver can't work as it should and its normal functions are impaired.

The best chance of long term neurologically intact (no brain damage) survival after cardiac arrest occurs if:

- the victim is witnessed to collapse
- CPR (cardiopulmonary resuscitation) is commenced immediately
- the cardiac rhythm is ventricular fibrillation or pulseless ventricular tachycardia
- defibrillation is performed as soon as possible

(Australian Resuscitation Council in *Emergency Medicine Australasia,* 2006)

Cardiopulmonary resuscitation (CPR)

Cardiopulmonary resuscitation (CPR) comprises those techniques used to minimise the effects of circulatory arrest and to assist the return of spontaneous circulation. CPR has 3 fundamental components:

- **A** Airway assessment and management
- **B** Breathing assessment and management
- **C** Circulation assessment and management

Basic Life Support (BLS) is the preservation or restoration of life by the establishment of and/or the maintenance of airway, breathing and circulation, and related emergency care. BLS is only a temporary measure to maintain normal ventilation and circulation. Effective external cardiac compression provides a cardiac output of only 20 to 30% of the pre-arrest value, and expired air resuscitation provides ventilation with an inspired oxygen concentration of only 15 to 18%.

Advanced Life Support (ALS) is basic life support with the addition of invasive techniques e.g. defibrillation, advanced airway management, intravenous access and drug therapy. The purpose of BLS is to help maintain myocardial (heart) and cerebral (brain) oxygenation until defibrillation, ALS personnel and equipment are available.
(Australian Resuscitation Council in *Emergency Medicine Australasia,* 2006)

It is unclear how long Ms Weazel was unconscious and pulseless before her resuscitation was attempted at the hospital. Mr Gyemore cannot recall specific times of events, and there is no way of judging this precisely.

In Dr Satyasiv's opinion, the low body temperature and dry corneas indicate Ms Weazel had been without cardiac output (her heart had stopped beating) for between 30 minutes and two hours before he examined her at about 4:25am.

On the account of Mr Gyemore, Ms Weazel lost consciousness at "The Farm" and the snoring reported by Mr Gyemore indicates Ms Weazel's airway was at least partially obstructed at that time. When a victim is unconscious, all muscles are relaxed, and the tongue, which is attached to the back of the jaw, falls against the back wall of the throat and blocks air from entering the lungs.

Even if basic life support had been available immediately on arrival at the hospital, it is probable the airway would have been obstructed for more than three minutes and this would have significantly compromised Ms Weazel's chance of surviving neurologically intact (without brain damage). In any event, advanced life support was not available until the medical officer arrived some 15 minutes later.

Given Ms Weazel's cardiac arrest occurred outside hospital, the airway was at least partially obstructed before arrival at the hospital, advanced life support by a medical officer was not immediately available, and the severe coronary atherosclerosis found at autopsy, it is more probable than not that Ms Weazel would not have survived neurologically intact even if the nursing staff had commenced basic life support immediately on Mr Gyemore's arrival.

4.7 Findings

1. There is reliable and independent evidence beyond any reasonable doubt that Mr Gyemore arrived with Ms Weazel at the Cherbourg Hospital at approximately 3:55am, police arrived at the hospital at 4:05am, and Ms Weazel was taken into the hospital at 4:08am.
2. The nursing staff of Cherbourg Hospital had an honest and reasonable but mistaken belief, that Mr Gyemore was a present and immediate threat to their personal safety, and the safety of inpatients at the Cherbourg Hospital, and the nurses were justified in refusing Mr Gyemore immediate entry to the Cherbourg Hospital until police arrived.
3. An inoperable audio intercom at the emergency entrance of the Cherbourg Hospital prevented effective verbal communication with Mr Gyemore, and contributed to the nurses' misunderstanding of Mr Gyemore's obvious distress and the actual emergency situation.
4. On the balance of probabilities, it is not likely that Ms Weazel would have survived neurologically intact even if the nursing staff had commenced basic life support immediately on Mr Gyemore's arrival.
5. The South Burnett Health Service District has taken appropriate remedial action to prevent a similar recurrence of this incident.

4.8 Recommendations (Death of Maureen Weazel)

I. That Queensland Health implement the findings of the root cause analysis into the circumstances surrounding the death of Ms Maureen Weazel, in particular:

- **(i) Undertake a daily check of the correct functioning of the security intercom;**
- **(ii) Provide nursing staff with orientation and training in the security camera equipment;**
- **(iii) Develop a formalised system/tool for reporting equipment defects, maintenance requirements and repairs; and**
- **(iv) Review the compliance of Cherbourg Hospital with the Australian Standard AS 4485 *'Security for health care facilities'*.**

II. That Queensland Health draws no adverse inference about the conduct of staff at Cherbourg Hospital in refusing Mr Gyemore entry to the hospital until police arrived.

III. That Queensland Health consult with the Department of Tourism, Fair Trading and Wine Industry Development about exemptions for security provider licensing to permit members of the Cherbourg Community to provide security services at Cherbourg Hospital.

5. Death of Dawn Chambers, aged 60 years

5.1 Background

About 2:00pm on 10 July 2006, Mrs Dawn Chambers presented to Cherbourg Hospital because she was out of medication for her long standing condition of heart failure. Mrs Chambers was reviewed by a medical officer and an x-ray was ordered.

At the time, the x-ray at Cherbourg Hospital was unserviceable, and Mrs Chambers was referred to Murgon Hospital for the x-ray. Mrs Chambers did not have personal transport, so Mrs Chambers walked down the street and hitched a ride to Murgon Hospital.

At 7:52pm, Mrs Chambers died at home from a cardiac arrest.

The following newspaper reports reflect the general concerns expressed by various members of the Cherbourg Community about the circumstances surrounding Mrs Chambers death.

The first report by Ms Annabelle McDonald was published in *The Australian* on Friday 21 July 2006 (Appendix 40).

> ***Hospital fails second dying woman***
> *By Annabelle McDonald*
>
> *An Aboriginal woman has died after being turned away from her local hospital and forced to hitchhike to a neighbouring town to receive medical attention.*
>
> *For the second time in as many weeks, staff at Queensland's Cherbourg Hospital failed to help a dying woman, further inflaming tensions in the local community, where even the Mayor concedes a riot might be the only way to have their plight heard.*
>
> *Dawn Chambers, 60, was told to find her own way from Cherbourg, west of Gympie, to Murgon 6km away because no one at Cherbourg Hospital could use its X-ray equipment. Mrs Chambers died of an apparent heart attack last Monday after going home to wait for test results that came back the next day.*
>
> *Her family is outraged Cherbourg Hospital staff did not call an ambulance or help arrange alternative transport for a woman who was clearly in pain.*
>
> ``*This should never have happened," Sam Chambers, 67, said yesterday, furious that his wife and the mother of their seven children was sent away then had to wait two hours for tests.*
>
> ``*I think all that rushing around during the day had a toll on her. What really gets me fed up is that she had to walk from the hospital down the road about 500m to wait for a lift to Murgon.*
>
> ``*I can't put that feeling into words. The hospital needs a good shake-up." Mrs Chambers died two days before her 61st birthday. Her family was planning a surprise party.*

Three days before Mrs Chambers's death, in the early hours of Saturday morning, 25-year-old Maureen Weazel was left to die outside Cherbourg Hospital, after nurses ignored her friend's frantic pleas. The hospital claimed a female patient mistook Ms Weazel's friend for her drunk and violent boyfriend, and asked for him to be kept out.

The Australian last week revealed the tragedy, which will be investigated by the Coroner acting on reports from Queensland Health and police.

But yesterday the only two female patients at the hospital that night denied instructing the nurses to ignore the man, who bashed on the doors for 90 minutes before police were called.

Patient Rosie Douglas, who was unaware her niece Maureen was dying in a car outside, said the three female nurses hid behind a wall in the hospital as the man screamed for help. Cherbourg Mayor Ken Bone has called for a government inquiry, accusing the hospital of covering up Ms Weazel's death.

Despite several calls to Queensland Health following the two ``unnecessary'' deaths this month, Mr Bone said no one had returned his calls.

``Do we have to riot like other communities to get attention?'' Mr Bone said yesterday. ``It looks as though, for us, the (Government) doesn't give a damn.''

A Queensland Health spokesman could not be contacted for comment on the Cherbourg case.

The state's public hospital system has been under increasing pressure in recent years.

Last night it emerged the hospital in the Aboriginal community of Doomadgee, on Cape York, went six weeks without reliable hot water earlier this year.

A Queensland Health spokesman said: ``In high summer in northwest Queensland, where temperatures may exceed 40C, the lack of hot showers tends not to be a major concern''.

The second report by Mr Sean Parnell was published in the *The Weekend Australian* on Saturday 22 July 2006 (Appendix 41).

Hospital 'not to blame' for two women's deaths
By Sean Parnell

THE Queensland health department has sought to ease tensions in the Aboriginal community of Cherbourg by offering a public explanation of the local hospital's role in the death of two women.

The Australian revealed yesterday that Dawn Chambers, 60, had fronted Cherbourg Hospital with chest pains and was told to travel to Murgon, 6km away, because none of the staff on duty could operate the X-ray machine.

Mrs Chambers, a married mother of seven, waited two hours for X-rays at Murgon and was allowed to go home where she died of a suspected heart attack last Monday. Her funeral was held yesterday, with tensions still high over that incident and another recent case where Maureen Weazel, 25, died outside the hospital a week ago.

Mrs Weazel died after staff refused to open doors for her frantic friend, whom they believed was her drunk husband.

Queensland Health yesterday confirmed X-ray services were not available at Cherbourg Hospital, but insisted transport to Murgon would have been arranged for any patient who required it. ``This patient was treated appropriately and competently,'' South Burnett Health Service district manager Rosemary Hood said.

The following newspaper report was published in *The South Burnett Times* newspaper on Friday 28 July 2006 (Appendix 42).

More 'black fellas'

Dawn Chambers' and Maureen Weazel's family members met with senior Cherbourg and South Burnett health workers on Monday to get answers into why the women died.

Councillors and community health workers were also on hand and asked for changes at Cherbourg Community Hospital to ensure further deaths did not happen.

All left despondent and feeling "everything will be swept under the carpet".

Queensland Health has refuted all accusations and witness statements regarding Ms Weazel and Mrs Chambers' death and Cherbourg councillor and Person of the Year Lillian Gray said no one felt confident their concerns had been taken seriously.

"We asked for indigenous staff to be put on at the hospital and they said they needed someone reliable and committed," Mrs Gray said in a quiet sad voice.

"That's degrading.

"They're saying all black fellas are lazy and not committed to the job.

"(Nursing Director, Elaine Berlin) had no right to say that."

5.2 Scope of investigation

The investigation into the circumstances surrounding the death of Ms Weazel focused on three principal issues:

1. Was the referral of Mrs Dawn Chambers to Murgon Hospital reasonable, having regard to the circumstances at the time?
2. Should Mrs Chambers have been assisted with, or provided transport to Murgon Hospital?
3. Could the death of Mrs Chambers have been prevented with more appropriate treatment or safeguards?

5.3 Investigation process

Interviews were conducted with relevant medical and nursing staff of the Cherbourg and Murgon Hospitals, and relatives of the deceased. Documents reviewed included medical records and documents pertaining to the internal investigation of Queensland Health. The HQCC obtained an independent medical opinion.

5.4 Independent medical opinion

An independent medical consultant to the HQCC reviewed the medical chart of Mrs Chambers and her attendance at Cherbourg Hospital on 10 July 2006.

The medical expert considered that the treating doctor's notes indicated a thorough examination of Mrs Chambers.

The consultant's impression was that Mrs Chambers presented as a chest infection rather than a cardiac condition. This was confirmed by the chest x-ray which indicated fluid in the right lower lobe of Mrs Chambers' lungs. There was no basis on which to suspect a heart attack later that evening.

The consultant was of the opinion that even if the treating doctor had admitted Mrs Chambers to hospital, or arranged transport to Murgon Hospital by ambulance, her heart attack would still have occurred.

5.5 Relevant standards, policies and procedures

Cultural Respect Framework For Aboriginal And Torres Strait Islander Health 2004 – 2009

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-crf.htm/$FILE/Cultural_Respect_Framework.pdf

The Cultural Respect Framework has been developed as a guiding principle in policy construction and service delivery to strengthen relationships between the health care system and Aboriginal and Torres Strait Islander peoples.

The Cultural Respect Framework recognises the following principles which are consistent with the National Aboriginal and Torres Strait Islander Health Strategy and the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework 2002*.

- **A holistic approach**: recognising that the improvement of Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social wellbeing, community capacity and governance.
- **Health sector responsibility**: improving the health of Aboriginal and Torres Strait Islander individuals and communities is a core responsibility and a high priority for the whole of the health sector. Making all services responsive to the needs of Aboriginal and Torres Strait Islander peoples will provide greater choice in the services they are able to use.
- **Community control of primary health care services**: supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health

services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way.

- **Working together**: combining the efforts of government, non-government and private organisations within and outside the health sector, including areas of employment, education and housing, and in partnership with the Aboriginal and Torres Strait Islander health sector, provides the best opportunity to improve the broader determinants of health.
- **Localised decision-making**: health authorities devolving decision-making capacity to local Aboriginal and Torres Strait Islander communities to define their health needs and priorities and arrange for them to be met in a culturally appropriate way in collaboration with Aboriginal and Torres Strait Islander specific and mainstream health services.
- **Promoting good health**: recognising that health promotion and illness prevention is a fundamental component of comprehensive primary health care and must be a core activity for specific and mainstream health services.
- **Building the capacity of health services and communities**: strengthening health services and building community expertise to respond to health needs and take responsibility for health outcomes. This includes effectively equipping staff with appropriate cultural knowledge and clinical expertise, building physical, human and intellectual infrastructure, and fostering leadership, governance and financial management.
- **Accountability for health outcomes**: recognising that accountability is reciprocal and includes accountability for health outcomes and effective use of funds by community controlled and mainstream services to governments and communities. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities.

Queensland Health's Directions for Aged Care 2004-2011

http://www.health.qld.gov.au/publications/corporate/agedcare/287817_ACCRU_5.pdf

The purpose of Queensland Health's *Directions for Aged Care 2004-2011* is to provide direction to health service providers on meeting older people's health and aged care needs while respecting their (and their carers') choices about that care.

Directions for Aged Care 2004-2011 is primarily targeted to those 65 years and over and those **45 years and over** who are from Aboriginal and Torres Strait Islander backgrounds. It recognises that many older Aboriginal and Torres Strait Islander peoples experience problems accessing appropriate levels of service, because they live in isolated communities in rural and remote areas of Queensland.

The principles underpinning *Directions for Aged Care 2004-2011* are:

1. Dignity
   - Valuing and supporting the dignity and diversity of older people
   - Respecting, protecting and promoting the rights of clients of health services, and their respective carers
2. Independence
   - Maintaining and where possible returning the client to previous levels of independence
3. Client focus
   - Organising services around meeting the needs of clients
   - Providing culturally respectful care
4. Access
   - Providing access to health services regardless of social, cultural or religious background, mental health status or location
5. Coordination
   - Linking clinical treatment and care that spans community, hospital and residential aged care settings
6. Quality
   - Providing services according to the *Aged Care Act and Principles 1997*
   - Providing treatment and care that meets industry best practice
7. Carer recognition
   - Recognising and supporting the valuable contribution of carers
8. Collaboration
   - Developing and strengthening partnerships with government and non-government providers

5.6 Discussion

Aboriginal and Torres Strait Islander peoples must receive care appropriate to their needs, and the policy of prohibiting any outpatient transport is not consistent with the purpose and intent of the *Cultural Respect Framework For Aboriginal And Torres Strait Islander Health 2004 – 2009* and Queensland Health's *Directions for Aged Care 2004-2011.*

The treating doctor was placed in a difficult situation commencing practice at Cherbourg Hospital immediately after his arrival by bus that day. This was the treating doctor's first experience in a rural Indigenous community, and he was not provided with appropriate training to deliver culturally appropriate health care to the Cherbourg Aboriginal Community.

The investigation demonstrates that the treating doctor's review and treatment of Mrs Chambers was good medical practice, and the death of Mrs Chamber could not have been prevented on the information known to the treating doctor at that time. The treating doctor was not aware of local transport difficulties and could not have been expected to understand the idiosyncrasies of the Cherbourg Aboriginal Community without an appropriate induction.

The Queensland Health internal investigation findings and outcomes are based in part on the belief that Mrs Chambers refused an offer of transport. This may also have been conveyed to the family of Mrs Chambers. This contradicts evidence given by the treating doctor to HQCC investigators. The root cause analysis does not address the appropriateness of the District policy prohibiting any outpatient transport.

There is no evidence that Mrs Chambers posed a threat to any staff of Queensland Health. Given that x-ray services which are routinely provided were not available, there was an expectation x-rays would be reviewed later that afternoon. Mrs Chambers could only walk 10 to 15 metres before becoming short of breath, and it would not be unreasonable to offer transport assistance.

There is a District policy in the South Burnett Health Service prohibiting outpatient transport in departmental vehicles. This was introduced following an incident in which a Queensland Health employee was assaulted by an outpatient while being transported.

The risks to the personal safety of Queensland Health staff and the potential for abuse of outpatient transport services are obvious, but they need to be appropriately balanced against the special needs of the Cherbourg Community, and in particular, older members of that community. Transport decisions should be based on clinical assessment of the individual patient, and a balanced assessment of the risks involved in transporting that patient.

5.7 Findings

1. The death of Mrs Chambers was not reasonably foreseeable by the treating doctor.

2. It is unlikely the death of Mrs Chambers could have been prevented even if transport to Murgon had been provided.

3. It would have been reasonable to assist Mrs Chambers with transport to Murgon Hospital, but this was contrary to hospital policy.

4. The treating doctor commenced relieving duties at Cherbourg Hospital without an appropriate understanding of the cultural environment and special needs of the Cherbourg Aboriginal Community, and in particular that a patient such as Mrs Chambers would have to hitch hike to Murgon Hospital to access x-ray facilities.

5. The internal investigation by the South Burnett Health Service District has not addressed the appropriateness of the District policy prohibiting any outpatient transport.

6. The policy of prohibiting any outpatient transport is not consistent with the purpose and intent of the *Cultural Respect Framework For Aboriginal And Torres Strait Islander Health 2004 – 2009* and Queensland Health's *Directions for Aged Care 2004-2011*.

5.8 Recommendations (Death of Dawn Chambers)

I. That Queensland Health review the root cause analysis into the circumstances surrounding the death of Mrs Dawn Chambers, taking into account the evidence of the treating doctor.

II. That Queensland Health review the policy in the South Burnett Health Service District (and elsewhere in Queensland) which prohibits the transport of outpatients in Queensland Health vehicles.

III. That Queensland Health, in consultation with the Cherbourg Aboriginal Community, develop and implement cultural awareness training at Cherbourg Hospital to improve staff knowledge and awareness about the physical, spiritual, cultural, emotional and social aspects of the Cherbourg Aboriginal Community.

IV. That Queensland Health draws no adverse inference about the conduct of the treating doctor and the treatment of Mrs Dawn Chambers at Cherbourg Hospital.

6. Death of Raymond Edwards, aged 65 years

6.1 Background

Mr Raymond Edwards was a long term resident of Ny-Ku Byun Aged Care Hostel, Cherbourg. The hostel is commonwealth funded and operated by the Cherbourg Aboriginal Shire Council.

Mr Edwards lived at the hostel from 1992 after he had a stroke which resulted in right sided residual hemiparesis (slight or incomplete paralysis affecting one side of the body) and expressive dysphasia (impairment of speech). Mr Edwards also suffered dementia, hypertension (high blood pressure) and depression.

On 25 February 2004, Mr Edwards was approved by an Aged Care Assessment Team as high care.

On 5 December 2005, Mr Edwards had a fall at the Ny-Ku Byun Hostel and was taken to Cherbourg Hospital with a fractured right hip. Mr Edwards was immediately transferred to Toowoomba Base Hospital for surgery.

On 13 December 2005, Mr Edwards was discharged from Toowoomba Base Hospital to Kingaroy Hospital and back to the Ny-Ku Byun Hostel.

On 21 June 2006, Mr Edwards had a fall at the Ny-Ku Byun Hostel and was taken to Cherbourg Hospital with multiple injuries including a swollen forehead, small laceration to tongue, a painful right hip with leg shortened and externally rotated, left jaw pain and swelling, and a painful right wrist with no deformity. The x-ray facilities at Cherbourg Hospital were not functional at the time and Mr Edwards was transferred by the Royal Flying Doctor Service to Toowoomba Base Hospital for investigation. A fractured patella (kneecap) was diagnosed, and a long leg plaster cast was applied.

On 28 June 2006, Mr Edwards was transferred back to Cherbourg Hospital with a long leg cast *in situ*, and on 7 July 2006, Mr Edwards was discharged to the Ny-Ku Byun Hostel with the long leg cast still *in-situ.*

On 11 July 2006, Mr Edwards was transferred back to Cherbourg Hospital with pressure sores on his thigh around the long leg cast. The top of the cast was cut.

On 17 July 2006, Mr Edwards was transferred back to Ny-Ku Byun Hostel with the altered long leg cast in situ.

At about 3:50am on 24 July 2006, Mr Edwards was admitted to Cherbourg Hospital with abdominal pain. Mr Edwards deteriorated during the day showing signs of being in shock.

At 6:00pm on 24 July 2006, Mr Edwards was transferred *in extremis* via Care Flight to Toowoomba Hospital. Mr Edwards was diagnosed with multiple medical co-morbidities and a decision was made by the consultant surgeon and anaesthetist that Mr Edwards was not suitable for surgical intervention. Mr Edwards died at 7:30pm.

6.2 Newspaper reports

The following newspaper report published in *The South Burnett Times* newspaper on Friday 28 July 2006 (Appendix 44) reflects the concerns expressed by various members of the Cherbourg Community about the circumstances surrounding Mr Edwards death, and the earlier deaths of Maureen Weazel and Dawn Chambers.

Hospital linked to three deaths in nine days

When a CareFlight chopper flew in to take Raymond Edwards to hospital with a busted bowel on Monday, people in Cherbourg thought "oh no, not again!"

The 65 year old man had been a patient of Cherbourg Community Hospital and died later that day.

The manager of the Ny-Ku Byun aged care hostel, where he lived, is blaming the hospital for Mr Edward's death.

Other residents have spoken of the "uncaring and flippant" attitudes at the hospital over the much publicised deaths of Maureen Weazel and Dawn Chambers recently.

They were speaking to the South Burnett Times about these concerns when the helicopter flew in to take Mr Edwards to Toowoomba Hospital.

Now Ny-Ku Byun's non-indigenous aged care hostel manager Samantha Sullivan has backed the way they feel.

She said Mr Edwards was a resident at Ny-Ku Byun hostel for 14 years and suffered great pain for weeks leading to his death on Monday.

It is claimed the hostel's staff rang the hospital at 2:30am that morning and were told to give Mr Edwards pain relief in the form of Panadeine Forte.

They had been giving the drug to the man during his intermittent visits to the wards for the previous three weeks.

The problem with Panadeine Forte is that it can cause severe constipation and Coloxyl Senna is needed as an antidote to free the bowel.

While the hospital staff gave the Senna laxative to Mr Edwards during his visits it is alleged they did not order it on his medical charts each time he was returned to Ny-Ku Byun.

His bowels apparently became bound and ruptured.

He was flown to Toowoomba but died.

Mrs Sullivan said the Cherbourg Community Hospital's doctors knew her staff could only follow orders given on medical charts.

She recounted stories of fractures going untreated and of a man who was sent to the hospital 10 times in three weeks "because he was very ill".

He was finally flown to Brisbane about two weeks ago where doctors found him bleeding internally.

"He's alive but he's lucky," Mrs Sullivan said.

Mrs Sullivan said she had made many complaints to the hospital's director of nursing Elaine Berlin during the four years she headed Ny-Ku Byun but no improvement had been made.

"I haven't even received any feed back," she said.

"I've also complained about the way that hospital's staff speak to mine.

"They're blunt and rude and belittling.

"I think they need to shut the hospital down and get some community input into it."

They've got one indigenous person on the payroll.

"They need more".

"At our hostel we've got many indigenous workers from management to care, to kitchen, domestic, laundry, every area we have.

"You need indigenous workers because I've been here four years and I'm still learning about their culture.

"It also lessens negative stereotypes. "

I think that's a problem at the hospital.

"When I talk to the staff at the hospital on the phone they think I'm indigenous and they're very rude, abrupt, short…

"Face to face they're polite and courteous.

"I think that says a lot."

Cherbourg Community Health employee Esme Fewquandie said the hospital had undergone many cultural awareness programs but it did not seem to make any difference.

She and other community members met with South Burnett Health District manager Rosemary Hood on Monday to speak about the death of Ms Weazel and Mrs Chambers but said they felt patronised and nothing would change.

"It's all well and good to say they're going to get a new intercom system, light and security cameras but what they need is a change in attitude," Mrs Fewquandie said.

"They need to respect aboriginal people."

Cherbourg mayor Ken Bone said there were still a lot of unanswered questions and called for an inquest into the deaths.

"Our main concern is that it doesn't happen again," he said after Mrs Chambers death 18 days ago.

Then the chopper flew in and took Mr Edwards away.

Health service refutes claims

Queensland Health has hit back at critics of the care given by Cherbourg Hospital staff saying public confidence in the hospital is reflected in the number of people arriving there for health care.

South Burnett Health Service District manager Rosemary Hood said despite issues raised by some Cherbourg people the number of people coming to the hospital for care has been "higher than normal during the past few weeks and days."

"The residents of Cherbourg continue to show their confidence by using the hospitals as their main health service."

Mrs Hood said in the past year 936 people have been admitted to the hospital, 3506 have been treated at Accident and Emergency and 8949 for outpatient care.

Regarding the case of Dawn Chambers who died recently Mrs Hood said she had not appeared to be acutely unwell" when she came to the hospital and did not say she was in pain.

"There was no evidence of any deterioration of her cardiac condition nor evidence of chest pain."

Mrs Hood said Mrs Chambers had come to the hospital for a prescription as she had not been able to get to her doctor in Murgon.

The doctor at the hospital medically examined her and referred her for a chest x-ray.

Mrs Chambers was told to come back to the hospital if she had concerns.

As Cherbourg Hospital's x-ray machine was not available the doctor asked Mrs Chambers if she had transport to go to Murgon and had an x-ray that afternoon."

As far as the death of Maureen Weazel was concerned Mrs Hood said claims her man friend tried to get help at the hospital for 90 minutes were untrue.

Cameras showed 10 minutes elapsed between the man arriving at the hospital and police arriving.

There is to be a coronial inquest into the death of Ms Weazel but Queensland Health is also to investigate matters involving the death of both Ms Weazel and Mrs Chambers.

Referring to the death of a man who had lived at Ny-Ku Byun Hostel Mrs Hood said Cherbourg Hospital had not been the main provider of his medical care.

Staff had only become involved when he came to the hospital for emergency care which, she said, was competently provided and organised his transfer to a larger centre.

Mrs Hood said several indigenous staff – clinical and non clinical – are employed by Cherbourg Hospital.

"Every effort is made to employ, train, support and retain indigenous staff but recruitment in the health care field is an issue right across Australia."

There are ongoing programmes to ensure doctors, nurses and other staff at Cherbourg Hospital are culturally aware and sensitive and she was proud of their professional and caring approach, Mrs Hood said.

6.3 Scope of investigation

The investigation into the circumstances surrounding the death of Mr Edwards focused on three principal issues:

1. Did Mr Edwards die from a perforated bowel due to, or as a consequence of, constipation?
2. Is there consistent continuity of care between the Cherbourg Hospital and the Ny-Ku Byun Hostel?
3. Could the death have been prevented with more appropriate treatment or safeguards?

6.4 Investigation process

In the investigation, interviews were conducted with relevant medical and nursing staff of the Cherbourg Hospital, Ny-Ku Byun Hostel and Blue Care Nursing Service, Murgon, together with relatives of Mr Edwards and the CEO of the Cherbourg Aboriginal Shire Council.

Documents reviewed included the deceased's medical records from Cherbourg and Toowoomba Hospitals, the internal investigation conducted by Queensland Health, Aged Care Standards Review Audit of Ny-Ku Byun Hostel.

6.5 Relevant standards, policies and procedures

Aged Care Act and Principles 1997 (Cwth)

The *Aged Care Act and Principles 1997* (Cwth) require providers to maintain an adequate number of appropriately skilled staff to ensure the care needs of residents are met, including skilled nursing staff where this is indicated by the needs of the residents.

The Aged Care Accreditation Standards are set out in the *Quality Of Care Principles 1997* (Cwth) and consist of 44 expected outcomes for quality of care and quality of life for the provision of residential care (http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-standard-facility-sacfindx.htm)

The Accreditation Standards apply equally for the benefit of each resident of a residential care service, irrespective of the resident's financial status, applicable fees and charges, amount of residential care subsidy payable, agreements entered into, or any other matter.

The standards do not set out the skills and qualifications required to perform different duties, rather, the appropriate response to a resident's needs will always be dictated by those particular needs. The critical issue is that a resident's needs are effectively met, and it is with this that the standards are necessarily concerned.

It is not expected that all services should respond to a standard in the same way. The objective of an accreditation audit is to check that a service has systems in place-that those systems are being implemented and that they do, in fact, sustain quality outcomes in the service's particular circumstances.

Assessment against each standard, therefore, focuses on the range of activities that a service's policies and practices provide in support of the standard. The outcome of an assessment is based on service management and staff demonstrating the policies and practices have been implemented and are effective in supporting the standards.

It is a requirement that, for all high care residents, initial and ongoing assessment, planning and management of care for residents are carried out by a registered nurse.

Where assessed care needs require nursing or other skilled staff, those staff must be engaged. For example, an expected outcome for residents with specialised nursing needs is that those needs are identified and met by appropriately qualified nursing staff.

- ***Residential Care Manual***
- ***Documentation and Accountability Manual***
- ***Standards and Guidelines for Residential Aged Care Services Manual***

(Australian Government, Department of Health and Ageing) (http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-manuals-rcm-rcmindx1.htm)

The *Residential Care Manual* explains the Commonwealth's policies and operational requirements and contains information on all facets of the changes to aged care brought about by the enactment of the *Aged Care Act 1997* (Cwth).

The *Documentation and Accountability Manual* is intended for use by all care staff employed in residential aged care facilities and complements the *Residential Care Manual*.

The Professional Nursing Practice page (Chapter 2) of the *Documentation and Accountability Manual* describes the relationship between professional nursing practice and residents in residential aged care facilities as *"a series of planned steps and actions directed towards meeting the needs and solving the problems of residents, their families and the community in which they reside".*

It is highlighted that:

> *Professional nursing practice may also determine liaison with others who have been previously involved in the care of newly admitted or readmitted residents.*
>
> *For example, many acute care hospitals are now using clinical or critical pathways for specific episodes of illness or surgery to ensure appropriate care within hospitals and beyond discharge.*
>
> *One of the objectives of using such care tools is to ensure a continuum of care, often referred to as seamless care. These pathways are created by multi-disciplinary teams.*
>
> *Residents whose care has been planned in this manner benefit from following those pathways after discharge into an aged care facility.*

Similarly, older people benefit from greater cooperation between the acute care and the residential aged care sectors in determining and facilitating effective care delivery.

If residents are admitted with discharge plans (such as clinical or critical pathways) from acute hospitals, professional practice would require nurses to liaise with their colleagues in other care settings to ensure smooth continuity of care.

Guidelines For Medication Management In Residential Aged Care Facilities
http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/nmp-pdf-resguide-cnt.htm/$FILE/resguide.pdf

The management of medication in aged care homes is a significant part of care provision.

The *Guidelines For Medication Management In Residential Aged Care Facilities* take into account existing professional standards and relevant legislation, and makes recommendations with regard to policies and practices in individual facilities to ensure that all areas of medication management and decision making function together as a coordinated whole using a teamwork approach.

Recommendation 4 provides in respect to '*Administration of medications' that:*

For residents who are not self-administering, medication administration should be undertaken by a registered nurse or authorised enrolled nurse. If a registered nurse or an authorised enrolled nurse is not available, it is recommended that the facility provide medications in dose administration aids. In all cases, medication should only be administered by qualified or suitably trained staff.

Cultural Respect Framework For Aboriginal And Torres Strait Islander Health 2004 – 2009 (Appendix 68)

The Cultural Respect Framework has been developed as a guiding principle in policy construction and service delivery to strengthen relationships between the health care system and Aboriginal and Torres Strait Islander peoples.

The Cultural Respect Framework recognises the following principles which are consistent with the National Aboriginal and Torres Strait Islander Health Strategy and the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework 2002*.

- **A holistic approach**: recognising that the improvement of Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social wellbeing, community capacity and governance.
- **Health sector responsibility**: improving the health of Aboriginal and Torres Strait Islander individuals and communities is a core responsibility and a high priority for the whole of the health sector. Making all services responsive to the needs of Aboriginal and Torres Strait Islander peoples will provide greater choice in the services they are able to use.
- **Community control of primary health care services**: supporting the Aboriginal community controlled health sector in recognition of its

demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way.

- **Working together**: combining the efforts of government, non-government and private organisations within and outside the health sector, including areas of employment, education and housing, and in partnership with the Aboriginal and Torres Strait Islander health sector, provides the best opportunity to improve the broader determinants of health.
- **Localised decision-making**: health authorities devolving decision-making capacity to local Aboriginal and Torres Strait Islander communities to define their health needs and priorities and arrange for them to be met in a culturally appropriate way in collaboration with Aboriginal and Torres Strait Islander specific and mainstream health services.
- **Promoting good health**: recognising that health promotion and illness prevention is a fundamental component of comprehensive primary health care and must be a core activity for specific and mainstream health services.
- **Building the capacity of health services and communities**: strengthening health services and building community expertise to respond to health needs and take responsibility for health outcomes. This includes effectively equipping staff with appropriate cultural knowledge and clinical expertise, building physical, human and intellectual infrastructure, and fostering leadership, governance and financial management.
- **Accountability for health outcomes**: recognising that accountability is reciprocal and includes accountability for health outcomes and effective use of funds by community controlled and mainstream services to governments and communities. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities.

Queensland Health's Directions for Aged Care 2004-2011 (Appendix 69)

The purpose of Queensland Health's *Directions for Aged Care 2004-2011* is to provide direction to health service providers on meeting older people's health and aged care needs while respecting their (and their carers') choices about that care.

Directions for Aged Care 2004-2011 is primarily targeted to those 65 years and over and those **45 years and over** who are from Aboriginal and Torres Strait Islander backgrounds. It recognises that many older Aboriginal and Torres Strait Islander peoples experience problems accessing appropriate levels of service, because they live in isolated communities in rural and remote areas of Queensland.

The principles underpinning *Directions for Aged Care 2004-2011* are:

1. Dignity
   - Valuing and supporting the dignity and diversity of older people
   - Respecting, protecting and promoting the rights of clients of health services, and their respective carers
2. Independence
   - Maintaining and where possible returning the client to previous levels of independence
3. Client focus
   - Organising services around meeting the needs of clients
   - Providing culturally respectful care
4. Access
   - Providing access to health services regardless of social, cultural or religious background, mental health status or location
5. Coordination
   - Linking clinical treatment and care that spans community, hospital and residential aged care settings
6. Quality
   - Providing services according to the *Aged Care Act and Principles 1997*
   - Providing treatment and care that meets industry best practice
7. Carer recognition
   - Recognising and supporting the valuable contribution of carers
8. Collaboration
   - Developing and strengthening partnerships with government and non-government providers

6.6 Discussion

Cause of death

The community's perception that Mr Edwards died of a ruptured bowel as a result of constipation is not correct. The clinical evidence clearly demonstrates that Mr Edwards died of an ischaemic bowel caused by underlying arterial disease.

An independent consultant to the HQCC reviewed the medical records, x-rays and CT scans of Mr Edwards and gave the following opinion:

- The cause of death was ischaemic bowel most likely caused by underlying arterial disease.
- There was no perforation of Mr Edwards' bowel.

- Mr Edwards' constipation is not relevant to his death.
- The CT scan films show that there was calcified plaque at the conjunction of two of the three major arteries supplying the bowel wall with oxygen (i.e. the superior and the inferior mesenteric arteries).
- The presence of intramural gas in the CT scan supports the fact that the bowel wall was starting to "putrify" because of ischaemia. It does not suggest perforation as the air is within the bowel, not in the peritoneal cavity.

Quality of care at Ny-Ku Byun Hostel

The Cherbourg Aboriginal Shire Council is the approved provider which operates the Ny-Ku Byun Hostel. As a result of a complaint by Dr Satyasiv about the number of falls at the Ny-Ku Byun Hostel, the Council asked for a report by Ms Noela Baigrie.

Ms Baigrie is a private consultant and is not affiliated with, or endorsed by, the Department of Health and Ageing or The Aged Care Standards and Accreditation Agency Ltd.

On 16 and 17 August 2006, Ms Baigrie reviewed the operations of the hostel. In the report, Ms Baigrie criticised the hostel's medication management, bowel management and the lack of qualified nursing staff to care for the high number of residents requiring high level nursing care. Ms Baigrie reported the following issues related to Mr Edwards:

- *The head carer stated that the Medical Superintendent gave a verbal order that if [Mr Edwards] required Panadeine Forte, the regular Panadol from the webster pack was to be withheld. This was only documented in the progress notes once on 8 July 2005. The remaining care staff were giving both medications while [Mr Edwards] was in the hostel. Management and the head carer were not aware of this practice.*

- *[Mr Edwards] was an inpatient in the Cherbourg Hospital for approximately four days and was discharge on the 17 July 2006. There is no evidence of any aperients being prescribed by a medical doctor in the residents medication chart from the 7 July – 24 July the day the resident died in hospital.*

- *[Hostel] management did not follow up with the Medical Superintendent at the hospital or the medical centre doctors to review the [Mr Edwards] medication regime and the need for aperients.*

- *[Mr Edwards] who is high care was discharged from the hospital on 17 July 2006 and there is no entry in the progress notes by management or any of the care staff until the 21 July 2006. This resident was recovering from a serious fall and was in severe pain and for 4 days staff did not document about his care needs.*

- *On the 23 July2006l, it was recorded on the bowel monitoring chart that [Mr Edwards] bowels had opened. When the carer was interviewed, it was probably "overflow" (a consequence of constipation). The carer had no training or education in continence management and therefore did not have the skills or the knowledge to accurately record and describe the bowel motion in the bowel chart and the progress notes.*

On 21 to 23 August 2006, The Aged Care Standards and Accreditation Agency Ltd assessed the quality of care by the Ny-Ku Byun Hostel against the 44 expected outcomes of the Accreditation Standards.

The review found the Ny-Ku Byun Hostel complied with 41 of the 44 expected outcomes. The assessment found the Ny-Ku Byun Hostel did not comply with the following expected outcomes:

- **1.8 Information Management**

  "There is not an effective information system in place as to ensure that care plans contain current information to guide staff practice and that the verbal system and communication book used to inform management and staff of changes to resident care needs does not always communicate changes to resident care needs".

- **2.4 Clinical Care**

  "Residents do not consistently receive appropriate clinical care as care plans do not always contain current information to guide staff practices. Verbals systems and the communication book used by care staff to communicate changes in resident care needs to management and other care staff do not consistently reflect information in progress notes".

- **2.7 Medication Management**

  "Whilst the home has processes to ensure the safe and correct medication management for resident's regular medication, when necessary medication is not managed safely and correctly".

The accreditation of the Ny-Ku Byun Hostel was to expire on 3 April 2009. Following the review audit, the accreditation was varied to expire on 3 October 2008. The Aged Care Standards and Accreditation Agency Ltd was satisfied the Ny-Ku Byun Hostel would undertake continuous improvement, and the Agency undertook to make support contacts to monitor progress with improvements and compliance with the Accreditation Standards.

The HQCC investigation revealed that the Ny-Ku Byun Hostel was without registered nurse coverage from 20 September 2006 to 13 December 2006. This was immediately reported to the Department of Health and Ageing, and immediate arrangements were made for daily registered nurse coverage.

On 20 and 21 December 2006, The Aged Care Standards and Accreditation Agency Ltd again assessed the quality of care by the Ny-Ku Byun Hostel against the 44 expected outcomes of the Accreditation Standards.

The review found the hostel complied with all expected outcomes. The assessment team recommended that the period of accreditation not be varied, and there should be a support contact within three months.

The review noted that a community nursing service was now visiting the Ny-Ku Byun Hostel daily to supervise care delivery and monitor resident wellbeing.

Ms Samantha Sullivan, who was the hostel manager, was subsequently charged by the HQCC with an offence of making a false or misleading statement to the HQCC, in that Ms Sullivan had falsely told investigators that the hostel had registered nurse coverage. On 24 April 2007, Ms Sullivan pleaded guilty to the offence in the Murgon Magistrates Court and was fined $750.

Prescription of aperients

The hostel medication chart shows that Panadeine Forte 'as required' was prescribed for Mr Edwards on his discharge from hospital on 7 July 2006, but no aperient was ordered. This appears to have been an oversight, because Mr Edwards was ordered Coloxyl with Senna while an inpatient of Cherbourg Hospital (although this was withheld on the night before discharge).

At the hostel, Mr Edwards was administered Panadeine Forte one to two times daily between 7 and 11 July 2006.

On 11 July 2006, Mr Edwards was re-admitted to Cherbourg Hospital, and Coloxyl with Senna was recorded by a nurse as one of Mr Edwards' medicines prior to presentation to hospital. It appears this may have been extracted from the medication chart of the previous hospital admission rather than the hostel medication chart. Aperients including Coloxyl with Senna, Lactulose and Movicol were administered regularly during this admission. However, Mr Edwards was not administered Panadeine Forte during this admission.

On 17 July 2006, the discharging doctor at Cherbourg Hospital discharged Mr Edwards *'on usual meds'*. It is not known why aperients were not ordered on the hostel's medication chart.

The threshold issue arising from this investigation is the continuity of care between the Cherbourg Hospital and the Ny-Ku Byun Hostel.

There needs to be greater trust and co-operation between the two facilities to ensure appropriate and continuing care for hostel residents, in particular high care residents.

The Ny-Ku Byun Hostel was originally a low care residential facility, but 'ageing in place' has significantly increased the number of residents requiring increasingly complex high levels of care. This is exacerbated by the increasing amount of post-acute care in the hostel that was formerly provided by hospitals.

There needs to be a process in place before residents are discharged from hospital back to the hostel to ensure hostel carers have appropriate equipment, skills and qualifications to deal with the post-acute care. In particular, caution

should be exercised to ensure high care residents are not returned to the hostel too early.

Communication between the two facilities needs to be enhanced to ensure the objectives of the *Cultural Respect Framework For Aboriginal And Torres Strait Islander Health 2004 – 2009* and *Queensland Health's Directions for Aged Care 2004-2011* are met.

A review of clinical handover between the two facilities is also needed with a view to providing a clinical pathway (or a detailed discharge plan of some other type) for specific episodes of illness or surgery so that hostel carers can meet the specialised care needs of high care residents, such as complex wound care, complex pain management and dialysis treatment.

Medical support for high care residents post hospital discharge needs to be reconsidered with a view to providing on-going medical services to high care residents in the hostel after discharge from hospital. Particular attention is required to linking clinical treatment and care that spans community, hospital and residential aged care settings. The appropriateness of referring hostel carers to 13HEALTH for advice after a resident is discharged from Cherbourg Hospital also needs to be reviewed.

6.7 Findings

1. Mr Edwards did not die from a perforated bowel due to, or as a consequence of, constipation.

2. There is conclusive evidence that Mr Edwards died of an ischemic bowel caused by underlying arterial disease.

3. The death of Mr Edwards could not have been prevented.

4. There was not consistent continuity of care between the Cherbourg Hospital and the Ny-Ku Byun Hostel.

5. A clinical review is required to evaluate the quality of clinical care delivered to three residents of the hostel(names withheld).

6.8 Recommendations (Death of Raymond Edwards)

I. That the family of Mr Raymond Edwards, be verbally briefed by the HQCC on the outcomes of this investigation.

II. That the Cherbourg Aboriginal Shire Council and interested members of the Cherbourg Community be verbally briefed on the outcomes of this investigation (not including confidential or private information).

III. That Queensland Health draws no adverse inference about the conduct of staff at Cherbourg Hospital in the treatment of Mr Raymond Edwards.

IV. That Queensland Health consult with the Cherbourg Aboriginal Shire Council and Barambah Regional medical Service to improve communication between the Cherbourg Hospital and Ny-Ku Byun Hospital

and improve the continuity of care and transfer of information when residents are admitted to, and discharged from, hospital.

V. That Queensland Health review the operations of Cherbourg Hospital to ensure they are consistent with the purpose and intent of the *Cultural Respect Framework For Aboriginal And Torres Strait Islander Health 2004 – 2009* and Queensland Health's *Directions for Aged Care 2004-2011* with particular attention to:

(i) Supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context;

(ii) Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way;

(iii) Linking clinical treatment and continuity of care that spans community, hospital and residential aged care facilities;

(iv) Discharge planning to residential aged care facilities with particular focus on wound management, medication management and continence care;

(v) The appropriateness of referring community residents receiving complex post-acute care (such as complex wound care, complex pain management and dialysis treatment) to the 13HEALTH telephone service; and

(vi) Preventing the premature discharge from hospital of high care residents requiring complex post-acute care.

VI. That Queensland Health conduct a clinical review of [three other residents].

7. Summary of recommendations

Recommendations (Death of Maureen Weazel)

I. That Queensland Health implement the findings of the root cause analysis into the circumstances surrounding the death of Ms Maureen Weazel, in particular:

(i) Undertake a daily check of the correct functioning of the security intercom;

(ii) Provide nursing staff with orientation and training in the security camera equipment;

(iii) Develop a formalised system/tool for reporting equipment defects, maintenance requirements and repairs; and

(iv) Review the compliance of Cherbourg Hospital with the Australian Standard AS 4485 *'Security for health care facilities'*.

II. That Queensland Health draws no adverse inference about the conduct of staff at Cherbourg Hospital in refusing Mr Gyemore entry to the hospital until police arrived.

III. That Queensland Health consult with the Department of Tourism, Fair Trading and Wine Industry Development about exemptions for security provider licensing to permit members of the Cherbourg Community to provide security services at Cherbourg Hospital.

Recommendations (Death of Dawn Chambers)

I. That Queensland Health review the root cause analysis into the circumstances surrounding the death of Mrs Dawn Chambers, taking into account the evidence of the treating doctor.

II. That Queensland Health review the policy in the South Burnett Health Service District (and elsewhere in Queensland) which prohibits the transport of outpatients in Queensland Health vehicles.

III. That Queensland Health, in consultation with the Cherbourg Aboriginal Community, develop and implement cultural awareness training at Cherbourg Hospital to improve staff knowledge and awareness about the physical, spiritual, cultural, emotional and social aspects of the Cherbourg Aboriginal Community.

IV. That Queensland Health draws no adverse inference about the conduct of the treating doctor and the treatment of Mrs Dawn Chambers at Cherbourg Hospital.

Recommendations (Death of Raymond Edwards)

I. That Queensland Health draws no adverse inference about the conduct of staff at Cherbourg Hospital in the treatment of Mr Raymond Edwards.

II. That Queensland Health consult with the Cherbourg Aboriginal Shire Council and Barambah Regional medical Service to improve communication

between the Cherbourg Hospital and Ny-Ku Byun Hospital and improve the continuity of care and transfer of information when residents are admitted to, and discharged from, hospital.

III. That Queensland Health review the operations of Cherbourg Hospital to ensure they are consistent with the purpose and intent of the *Cultural Respect Framework For Aboriginal And Torres Strait Islander Health 2004 – 2009* and Queensland Health's *Directions for Aged Care 2004-2011* with particular attention to:

(i) Supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context;

(ii) Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way;

(iii) Linking clinical treatment and continuity of care that spans community, hospital and residential aged care facilities;

(iv) Discharge planning to residential aged care facilities with particular focus on wound management, medication management and continence care;

(v) The appropriateness of referring community residents receiving complex post-acute care (such as complex wound care, complex pain management and dialysis treatment) to the 13HEALTH telephone service; and

(vi) Preventing the premature discharge from hospital of high care residents requiring complex post-acute care.

IV. That Queensland Health conduct a clinical review of [three other residents].