SOUTH AUSTRALIAN MEDICAL EDUCATION & TRAINING HEALTH ADVISORY COUNCIL

Project Closure Report

Reporting Deaths to the State Coroner

Government of South Australia
SA Health

1. Introduction

1.1. General Outline

It is mandatory for medical practitioners to know and understand their obligations under the Coroners Act 2003. It is a requirement of this legislation that medical officers report deaths, in certain circumstances, to the SA Coroner. There are penalties which can be applied for not reporting a death to the Coroner.

The State Coroner provides an Annual Report to the Attorney General's Office each financial year. In the 2015-2016 Annual Report the Coroner detailed issues occurring in regards to the completion of reporting of deaths to the State Coroner's Office.

These issues include:

- Incorrectly reporting a death,
- Not reporting a death which should have been reported,
- Lack of information on the Medical Practitioners' Medical Deposition Form,
- Poor quality of information in the Medical Practitioners' Medical Deposition Form,
- The high number of phone calls received by the State Coroner's Office asking for direction in regards to reporting a death.

The Coroner also noted a 'worrying trend' that interns are incorrectly or incompletely completing the *Death Report to Coroner - Medical Practitioners Deposition Form* resulting in a decisions to perform a post-mortem to gain further understanding of the cause of death. This may not have been necessary if a senior practitioner with knowledge of the patient had completed the form.

The Coroner stated in his State Coroner Annual Report 2015-2016 'SA Health should take measures via their Risk Management departments to provide training and guidance regarding reportable deaths.'

1.2. Document Purpose

SA Health commenced a Coroner's Act Compliance Audit in August 2016. The audit identified issues including a requirement to undertake a range of activities to increase awareness of education and training for staff in their reporting obligations. The report recommended that SA MET develop a coronial reporting e-learning training module to be made available to all medical staff and other work groups such as nurses and midwives where relevant. The module was to include a frequently asked question document and examples of case studies within the training to assist clinicians to identify when to refer a death to the SA Coroner.

1.3. Key Positions

Project sponsor: Professor Paddy Phillips, Chief Medical Officer/Chief Public Health Officer

Project manager: Ronda Bain, Regional Training Manager

Project officer: Stacey Holst

On-line Services Support Officer: Sonya Thomas

2. Project Performance

2.1. Project Objectives

The training created by SA MET will improve and enhance SA Health's reporting of reportable deaths to the State Coroner. This includes understanding what deaths are reportable under the *Coroner's Act 2003* and improving the quality of the *Death Report to Coroner - Medical Practitioners Deposition Form* submitted to the Coroner.

2.1.1. Achieved

An e-learning training module was created for state-wide implementation for Junior Medical Officers (JMOs) to enhance SA Health's medical officers' understanding on how and when to report reportable deaths to the State Coroner.

The project scope was extended to encourage nursing, midwifery and senior medical practitioners to undertake the e-learning training module and the training module was launched state-wide. In addition, the Executive Directors of Medical Services (EDMS) committee agreed and approved that the e-learning training module would be a mandatory requirement for all medical officers.

2.1.2. Not Achieved

As of the 30 September 2018, a state wide policy and associated documents (including checklist) have not been released. This was not a responsibility of SA MET. As such the training is not 'sitting' within a broader information package.

2.2. Deliverables

The Project Manager and Project Officer met with a wide-range of stakeholders with specific expertise during the consultation period: Audit and Risk, Safety and Quality, Nursing and Midwifery, State Coroner's Office, Media and Communications and the SA Health medical officer cohort.

Deliverable	Delivered (Yes/No)	Form they were handed over in	Who Responsible	Completion Date		
				Planned	Revised	Actual
Project Plan approved	*Y*	*Soft copy and hard copy*	*SA MET*	*Feb 2017*		*Feb 2017*
Project discussions with corporate office and targeted partnerships	*Y*	*Face to face and email*	*SA MET*	*Feb 2017- July 2017*		*Feb 2017- July 2017*
Meet with Communications Team to set up a communications plan	*Y*	*Face to face*	*SA MET*	*July 2017*		*July 2017*
Feedback from the Coroner's office on the content	*Y*	*Face to face and email*	*SA MET*	*July 2017*		*July 2017*
Pilot e-learning module	*Y*	*OTIS*	*SA MET*	*August 2017*		*August 2017*
Frequently asked questions document approved	*Y*	*Document*	*SA MET*			*Sept 2017*
Amendments to the module	*Y*	*Email*	*SA MET*	*Sept 2017*		*Sept 2017*

Final e-learning module set up	*Y*	*OTIS & LHN learning platforms*	*SA MET & LHN*	*Nov 2017*		*Jan 2018*
Liaise with MEOs, DCT & ICT at each LHN as per communication plan	*Y*	*Face to face and email*	*SA MET*	*Nov 2017*		*Nov 2017*
Implementation across SA Health	*Y*	*Executive Check & LHNs' online platforms*	*CMO & LHNs*	*Dec 2017*		*Jan 2018*
Thanking Stakeholders for their involvement	*Y*			*Feb 2018*		*Feb 2018*
Statistics from LHNs on completion of e-learning by medical staff	*Ongoing*			*Mar 2018*		*Ongoing*
Evaluation of the e-learning module	*Y*	*Survey*	*Participants*	*June 2018*		*September 2018*
Evaluation of the Project	*Y*	*Closure Report & SA MET meeting*	*SA MET*	*June 2018*		*September 2018*
Closure Report approved	*Y*	*Report*	*SA MET*	*June 2018*		

2.2.1. Scheduling

There were some delays throughout the project which did have an impact on the e-learning module timelines of the project.

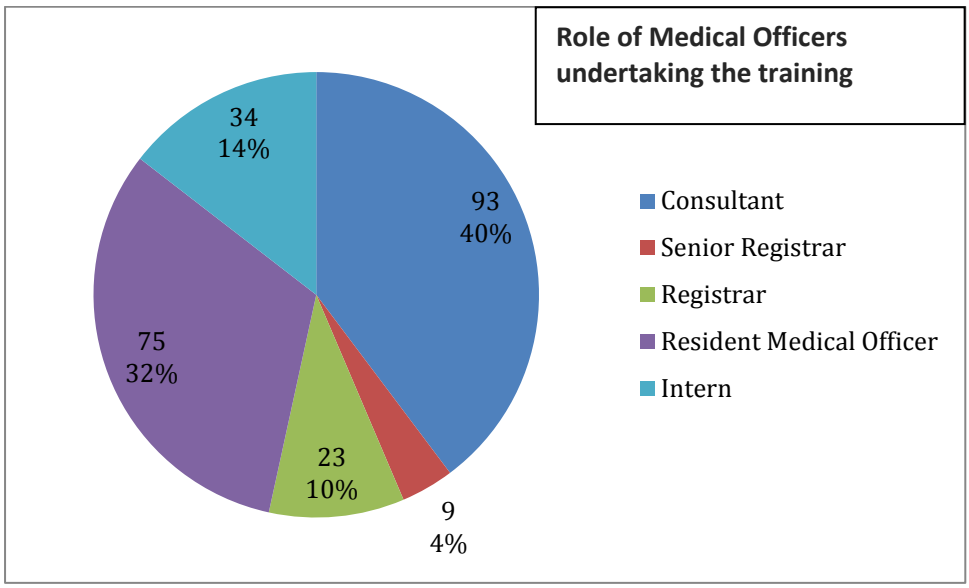
- The project scope was changed over the development of the project to include additional stakeholders and training participants including South Australian Ambulance Service (SAAS).
- The EDMS committee approved the e-learning module to be compulsory for all medical officers to undertake the training.
- The part-time nature of the on-line support officer who prepared the e-learning module and the Christmas Season resulted in a delay in updating the module with the amendments received as part of the pilot.
- The Coroner's office was contacted to review the initial draft to ensure the learning module questions were aligned with legislation correctly and the Coroner's interpretation. The delay in responding to the initial draft held up further development of the e-learning module to the next stage.

2.2.2. Closure

The project is considered closed when:

- The e-learning module has been implemented across SA Health on LHN learning platforms.
- Professor Paddy Phillips communicates the e-learning program as an Executive Update.
- Once there is sufficient feedback stating the training was useful for at least 80% of participants and that they have evaluated their knowledge after completing the e-learning module and agree that their knowledge has increased on the legislation and Coroner's requirements.

As of the 30 September 2018 nearly 500 doctors have completed the online training and of those 236 have completed the evaluation of the training. In addition another 112 nursing staff and 21 other staff (including Allied Health and Administration) have completed the evaluation of the training making a total of 369 completed evaluations.



Over 85% of participants took between 15-45 minutes to complete the training with four people taking over an hour to complete the training. Over 96% of participants reported that they felt the training will assist them to make an informed decision on whether or not to report a death to the Coroner. The participants were asked to evaluate how much the training had improved their knowledge and the average increase in knowledge was of 51%. Participants were provided with an opportunity to provide comments on the training and 62 people made comments. Six comments were concerning some difficulties undertaking the training and there will be some changes made in January 2019 to address these. Three comments were made stating that they disagreed with the action within the scenario however these have been confirmed by the Coroner's office as correct. Positive comments included

Really liked the scenario based training

I thought the scenarios were well constructed and realistic

Very useful range of scenarios, covering key details or aspects of the Act commonly encountered in the hospital context

The training will be reviewed in January 2019 to ensure that it remains current to the legislation and at this time changes will be made. Nursing staff undertook this training and there was a request to create training from the nurse's perspective to detail what actions are to be undertaken once the death of the patient is reported to the SA Coroner. There may be an opportunity to create the training for the Office of Nursing.

This project is considered closed.

3. Project Closure Summary

3.1. Document Control

Documents for this project are located within SA MET Y:\Company Data\Coroners reporting

3.2. Risks

Establishment\Project Plans & Registers. Risks were:

Outstanding / ongoing risks	Recommended action to manage outstanding / ongoing risks	Risk rating	Risk owner
Poor stakeholder assistance in the program leading to failing to create a robust and comprehensive e-learning program.	• Ensure that all stakeholders are included in discussions concerning reasons for training. • Seek an executive update from the Chief Medical Officer to launch the training which will go to all stakeholders. • Seek assistance of the EDMS committee to support and promote the project.		SA MET
The State Coroner's Office will not offer advice on the e-learning training program content.	• Develop a relationship with the Coroner's Office Manager thereby encouraging their participation in providing feedback. • Meet with the Coroner's Office Manager to seek Coroner feedback. • Provide the Coroner with a draft of the program before it is implemented across SA Health.		SA MET
Poor uptake from Interns and PGY2+s to undertake the e-learning program.	• Interns and PGY2+ were asked to contribute to the training by competing the pilot training and to provide input. • The project was tabled at the JMO Forum noting the importance of the reporting and the need for their input into the training. • Notify MEOs and DCTs of Training available for distribution.		SA MET
Lack of knowledge of available training to SA Health medical officers.	• Liaise with media and communications to provide a comprehensive communication plan to successfully implement the e-learning program. • Involve Professor Paddy Phillips in the communication plan to address to all medical officers across the State. • EDMS to support the program and compulsory participation. MEOs to monitor completion of JMOs.		SA MET
Term supervisors, JMOs and other medical education officers refuse to undertake this training.	• As the EDMS committee declared the e-learning compulsory and all medical officers should complete the training, support will be sought from the EDMS to promote and ensure medical officers complete the training. • Liaise with MEOs and DCTs to introduce		SA MET

	the training to term supervisors and medical officers within their LHN.		
Difficulty in dealing with different LMS and which LHN they belong to e.g. CHSALHN is SALHN, DASSA is SALHN, SA Pathology is CALHN	• Liaise and develop relationships with LMS managers across the state. • Liaise with the LMS managers to enable training for all medical officers.		Learning Management System
LHNs not timely uploading the training to their local LMS and adding participants on OTIS.	• Liaise with EDMS, MEU and LMS at each site to ensure that the e-learning platforms are working appropriately and that medical staff are completing the program. • Ascertain LHN e-learning procedures and note in this closure report.		SA MET

3.3 Risks

Outstanding / ongoing issues	Recommended action to manage outstanding / ongoing issues	Resolution Date	Issue owner
Buy-in from LHNs to continue to monitor the compulsory e-learning program	• Liaise with LMS managers to ensure they provide numbers of completed training to monitor uptake. • Creating time limits for compulsory completion of the training.	March 2018	LHNs & SA MET

3.3. Lessons

3.3.1. Successes

No	Description	Suggested Future Action (if any)
1.	The buy-in from units and medical staff who provided their feedback on the initial draft enabling modification to suit their needs. This resulted in a robust e-learning program.	N/A

Opportunities for Improvement

1.	Liaise with online services within SA MET to specifically discuss what is needed and deadlines that need to be met (e.g. Training presentation set up & LMS systems).	• A procedure to be written providing a template to complete when services are required from the online team. • Meet with the online team on how the program will be developed, scheduling responsibilities, FTE required to meet deadlines and any risks which may delay the project e.g. selecting images.
2.	Add into the Project Plan a schedule setting out the responsibilities for each stakeholder e.g. what is required, when required and how many FTE is required to meet stakeholder responsibilities.	• Obtain buy-in and establish relationship with the Coroner and the Coroner's office. • Liaise and establish relationships with stakeholders e.g. LHN Audit and Risk and Quality and Safety. • Liaise with the EDMS on LHN responsibilities.
3.	Understand the relationship with and involvement of SAAS in training requirements and include them in discussions.	Establish contact and include SAAS in discussions.

3.4. Post Implementation Review (Benefits)

Reporting measures to ensure that the program will continue to provide benefits

No.	Review Task (Benefit)	Measure	Date	Person / Team Responsible
1.	EDMS to ensure that the requirement for this training to be compulsory is met and continues within their reporting structures.	Yearly review of the program	Ongoing	SA MET and LHNs
2.	Seek information from the Coroner's Office to determine if calls from medical officers seeking advice has reduced.	Coroner's Office feedback	September 2019	SA MET

3.5. Post Project Tasks

The project will be closed and the following post project tasks are to be completed as part of the 'business as usual' phase:

No.	Description	Completion Date	Owner/s	Notes
1.	A Project Closure Report to be sent to Paddy and EDMS on the compliance of compulsory learning of medical staff	October 2018	SA MET	
2.	EDMS to ensure that the compulsory learning measures are met and continue within their reporting structures.	Yearly	SA MET	
3.	Monitor legislation and SRFs to ensure the training program continues to be relevant.	Ongoing	SA MET	

4. Project Closure Recommendation

Based on project performance, it is recommended that the project be closed.

The following recommendations are made:

4.1 State-wide e-learning platform

It is difficult to ensure that state-wide training is available for all medical officers in the state. There is no common Learning Management System across all LHNs. This caused a delay and does make monitoring of the number of doctors completing the training more complicated as each LHN needs to supply this information. The LHNs provided assistance to roll out the mandatory e-learning training. Further complicating the training development is the differing requirement of each LHN learning management system and this increases the time taken to create and launch the training. A single learning management system across the state would simplify the process of creating state-wide online learning.

SA MET will continue to monitor results from the survey (with the cooperation of the LHNs) to ensure that the objectives are continuing to be met. The numbers of medical officers completing the training will be reported to the EDMS committee meeting quarterly. Should numbers of medical officers completing the training not continue to grow further communication will be undertaken (e.g. Chief Medical Officer to send out reminder, EDMS to remind medical officers).

4.2 Stakeholder Relationships

SA MET to continue the relationship with the Office Manager at the Coroner's Office for ongoing development and update of the training.