



**The Hon Roger Cook MLA
Deputy Premier
Minister for Health; Mental Health**

Our Ref: 60-08803

PERTH CORONERS COURT

Ms Dawn Wright
Manager Listings
Office of the State Coroner
Level 10, Central Law Courts
501 Hay Street
PERTH WA 6000

24 JUL 2018

RECEIVED

Dear Ms Wright

Thank you for your letter of 30 April 2018 regarding the completion of the coronial inquest into the circumstances surrounding the death of HLS (name suppressed). I note the recommendations made by Coroner Linton.

The Department of Health's Coronial Review Committee is due to review the findings during the next scheduled meeting. The Committee will determine what actions should be taken at a system level to address the recommendation. Following this discussion, relevant services will be responsible for developing strategies that are necessary to implement the recommendation. Any further actions taken by the WA health system in relation to the recommendation will be included in the Coronial Liaison Unit's routine six-monthly progress reports to the State Coroner.

Some of the actions already in place include health assessments and screening, which take place across the WA Country Health Service (WACHS) "*Healthy Country Kids Program*." Under this program Community Child Health Nurses (employed by WACHS or contracted Aboriginal Medical Services) offer child health checks and administer the "Ages and Stages Questionnaire (ASQ)", which is a parent/carer completed screening tool to identify those children with, or at risk of, developmental delay.

- The information from the questionnaire is used when child health staff assess all children. There are two variants of this questionnaire, one specifically for Aboriginal Children called ASQ Trax, which covers from 6-48 months of age.
- The screening referred to in the WACHS's suggested recommendations is assessment and screening only; not a tool for diagnosis.
- If the assessment/screening identifies a problem then the child is referred to a Child Development Service for further assessment.

Additionally, WACHS has implemented an alert procedure in the Patient Administration system, which flags children at risk. The alert is for unborn and children 0-18 years with the alert placed in the mothers records for unborn. A range of indicators for concern are listed and includes current family alcohol/drug misuse.

Further, WACHS supports that screening of pregnant women for alcohol use should continue and support should be provided to pregnant women for alcohol use. Regarding the suggested recommendation (Part 1), "all women in WACHS should be screened ante-natally for alcohol use", it should be noted that this has been a mandatory screening field since July 2017; however screening requires the woman to attend for antenatal checks. The 2016 Closing the Gap report shows promising national trends on antenatal attendance: in 2011 85% of Aboriginal women attended five or more antenatal visits, by 2015 this had increased to 88%. The percentage of Aboriginal women attending antenatal appointments in the first trimester has improved dramatically from 41% in 2010 to 57% in 2015.

I trust that this information, and that provided in the ongoing six-monthly reports, will assist the State Coroner to fulfil the annual reporting requirements to the Attorney General.

Thank you for bringing this matter to my attention.

Yours sincerely

HON ROGER COOK MLA
DEPUTY PREMIER
MINISTER FOR HEALTH; MENTAL HEALTH

19 JUL 2018