Chad RILEY

Chad RILEY, aged 39, died on 12 May 2017 after being restrained by police officers. Shortly after midnight on the day of his death Mr Riley was taken voluntarily to the Royal Perth Hospital (RPH) Emergency Department by Police. Mr Riley was triaged, and he requested to speak with the pysch team. Attempts to engage Mr Riley in conversation were made by several nurses and doctors with no success. Mr Riley did not wait to be assessed by a doctor in the Emergency Department. Over the next seven hours Mr Riley was seen on CCTV returning to the Emergency Department on a further four occasions each for a short period of time before leaving again and did not wait to be triaged. At the inquest it was noted that these four attendances may have gone unnoticed by Emergency Department staff. Shortly prior to midday Mr Riley was approached by Police in East Perth who were concerned that he required medical care and called for an ambulance. Mr Riley suddenly became engaged in a struggle and he was restrained by Police in a prone position. Whilst being examined by a paramedic Mr Riley stopped breathing, CPR was commenced, he was taken by Ambulance to the RPH Emergency Department however could not be revived.

The Coroner made six recommendations, two were directed to the East Metropolitan Health Service (EMHS) and 4 were directed to the Western Australian Police Force. The recommendations to the EMHS focussed on patients who do not wait to be seen after registration at ED and the availability of Aboriginal Liaison Officers.

The CRC has reviewed these findings and made enquiries with the relevant stakeholders.

CRC Members agreed that the recommendations directed to the EMHS were applicable to all Health Service Providers. The WA Country Health Service (WACHS) *Management and Review of 'Did Not Wait' Patients that Present to Emergency Services Policy* outlines the process of management and review for those patients who did not wait for treatment after triage and the WACHS duty of care for the presenting patient. WACHS is currently the only Health Service Provider with a did not wait policy. However, in the absence of a policy all Health Service Providers advised that established processes are in place to identify and follow up patients who do not wait and confirmed further actions have been identified to strengthen these processes. The EMHS indicated that a did not wait policy is currently in development, informed by the WACHS policy. Advice included that The South Metropolitan Health Service (SMHS) intend to develop a do not wait policy, the North Metropolitan Health Service are undertaking further liaison to identify if a policy will benefit NMHS patients and the Child and Adolescent Health Service currently has a work instruction, and are formalising a procedure based on a recent audit and the WACHS policy. Health Service Providers have a number of mechanisms to monitor patients who do not wait including indicators in the Health Service Performance Report. The EMHS advised a combined discharge against medical advice and did not wait action plan has been developed, outlining a 12 month strategy to reduce both types of events.

WACHS advised a number of strategies that support the implementation of the did not wait policy. These include flow charts, referral to the local Aboriginal Medical Service if the patient cannot be reached, direct referral into homecare programs, increased

waiting room nurse positions, Aboriginal Liaison Officer (ALO) presence in emergency department waiting rooms and increase in social work hours. Strategies also include identification of patients on webPAS with high risk of DNW to allow early assessment and follow-up of these patients on re- admission.

EMHS completed a review of the ALO resource allocation including specific ALO allocation to the Emergency Department during business hours. To support the provision of additional services where they may be most beneficial, an analysis of Emergency Department presentations from

patients that identify as Aboriginal is being conducted to address service gaps and support improved ALO rostering practices, during and outside of business hours on any day of the week. Furthermore, the health service has committed to recruiting an additional 5 FTE, which is above EMHS allocated budget, to support its commitment to enhancing ALO service provision and the subsequent standard of care to Aboriginal people. Other Health Service Providers advised that they currently provide a Monday to Friday ALO service, with only some hospitals providing an out of hours service with coverage to the Emergency Department. One Hospital is currently extending this service to the Emergency Department and is seeking to identify ways to increase access to seven days. Another hospital advised that a oncall service was trialled with coverage on weekdays from 9:00am to 5:00pm, however the service ceased due to minimal uptake and maintaining staffing for the on-call service. Another Health Service Provider advised they will monitor the demand for ALO services and consider providing services outside of working hours if required.

CRC members observed the link to the previous coronial inquest into the death of Levi Shane Congdon and use of the term excited delirium. Members also observed the link to the Victorian and New South Wales coronial inquests which recommended that the term excited delirium be removed from all police training material until such time that it is recognised by the relevant Australian Colleges. It was determined that advice should be sought from the colleges representing pathologists, emergency physicians and psychiatrists to determine their position on the use of the term. At time of publication of this report responses had been received from the The Royal Australian and New Zealand College of Psychiatrists (RANZCP) and Royal College of Pathologists of Australia (RCPA), and a response pending from the Australasian College for Emergency Medicine (ACEM). RANZCP advised that the college publishes a range of statements and guidelines to inform the work of its members, and that none of these publications make specific reference to excited delirium, nor is it included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases 11th edition (IDC-11). The RANZCP is supportive of ongoing training for police and other relevant professionals in the management of people with agitation and behaviour disturbance, and that given the term excited delirium is not used within guidelines for psychiatrists it should not be the primary focus of any police training. Training should include understanding of the terminology commonly used for people suffering from this condition, in a way that communicates the emergency nature of treatment required. Terminology commonly used includes acute behavioural disturbance or agitated delirium. Similarly, the RCPA advised that the college does not have a Position Statement on the use of the term Excited Delirium. The RCPA went onto provide further advice that police training should include the dangers of physical restraint especially in potentially intoxicated or agitated

persons. The CLU will consider the advice of RANZCP and RCPA in relation to an existing action arising from the Congdon coronial inquest and WA Police.

Progress of these two recommendations will be updated in the next biannual report.