

Jared Charles OLSEN

Jared Charles Olsen, aged 41 years, died on 5 March 2015 as a result of fulminant sepsis (*Klebsiella pneumoniae*) with multi-organ failure complicating severe pancytopenia following the administration of 6-Mercaptopurine in a man with acute severe exacerbation of chronic colitis (Crohn's) and TPMT (thiopurine methyl transferase) deficiency. A test for TPMT detected the deficiency; however, the result was not communicated adequately and not actioned.

The Department of Health's Coronial Review Committee has reviewed these findings and made enquiries with relevant stakeholders across the WA health system.

In order to ensure results are followed up and appropriately actioned when a patient has been discharged from hospital before a test result is returned, the Fiona Stanley Fremantle Hospitals Group (FSFHG) has issued revised instructions on how to create lists in iCM by specialty for patients recently discharged which can be used for both pathology and imaging results. Further, PathWest has expanded its list of critical results limits and has updated its processes in relation to this.

As an additional short term measure, the FSFHG has introduced a Failsafe Alert system working in parallel to the existing iCM based system. This system is based on the patient administration system and allows radiologists to highlight requests where: a) critical or urgent findings are detected and it is has not been possible for the radiologist to discuss the findings with a member of the treating team; b) a probable or definite cancer is detected; or c) significant, important, unexpected and actionable findings are detected.

In the longer term, FSFHG is implementing the BOSSnet results management module that has the ability to "push" test results to treating clinicians rather than relying on clinicians to seek results.

The Coronial Review Committee considered that a central operational directive or instruction would not be effective in treating the risk. Further, health services maintain policies and procedures appropriate to their operational requirements. Health Service Providers have reported a range of strategies to manage or improve results follow-up, which includes the ongoing monitoring of compliance and performance in relation to results management and completion of discharge summaries.

Of the two recommendations made by the coroner, one has been duly considered and

deemed closed; and one is ongoing at the time of this report. Progress will be updated in the next report.