CHILD AM

Child AM, aged 3 years 11 months, died on 4 September 2015 from bronchopneumonia in an infant with obstructive sleep apnoea. Child AM was born in a remote community in the East Kimberley. She was evacuated from her community multiple times with obesity-related health issues, spending time in Broome Hospital, Royal Darwin Hospital, Halls Creek Hospital and Princess Margaret Hospital (PMH). Her final admission to PMH to monitor her respiratory conditions and introduce controlled weight loss programs was prolonged, after which time she was discharged into the care of a foster carer. She had also been referred to the Changes in Lifestyle are Successful in Partnership (CLASP) Service, which has since been replaced by the Healthy Weight Service (HWS) at Perth Children's Hospital (PCH). Two months after her last admission to PMH, Child AM died unexpectedly at home. She had fallen asleep on the floor in front of TV as was common for her and, when her foster carers tried to move her, they found that she was unresponsive. Resuscitation efforts were unsuccessful.

The Coroner made two recommendations related to the HWS at PCH including to introduce an outreach service and for the service to be culturally appropriate for Aboriginal families.

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

The CLU sought advice from the Child and Adolescent Health Service (CAHS). Following receipt of the CAHS response, advice was sought from the WA Country Health Service (WACHS). CAHS advice indicated that the HWS is a family-based lifestyle and weight management program at PCH. Children who meet the eligibility criteria are required to regularly attend PCH for a period of 6-12 months. Children not meeting the eligibility criteria or families unable to commit to the requirements for attendance are referred to alternative services. CAHS opined that extensive programs with significant face to face requirements cannot be delivered via outreach. Further CAHS acknowledged the limitations in service delivery models, as CAHS does not have a statewide remit for paediatric services and has no oversight of paediatric services provided by other Health Service Providers including WACHS. However, successful collaboration examples between CAHS and WACHS through established care pathways that enables tertiary care for country children were observed.

Early consultation has occurred between CAHS and WACHS to determine how best to approach children with severe obesity in the regions. Initial discussions suggest upskilling of local health care providers to deliver similar but not identical programs to the HWS would be the most cost effective and easiest to resource. Local demand and ability to maintain suitable staffing were acknowledged as limitations. Ongoing consultation is required to quantify what services currently exist in WACHS regions and how these can be supported and expanded or developed.

CAHS acknowledged the increasing need for the WA health system to deliver services that are culturally appropriate across Aboriginal and Culturally and Linguistically

diverse (CALO) communities. However, it was opined that for a program to be applicable across the whole state and be successful, it must be tailored to and led by the local Aboriginal community and their Elders and capacity to do so is limited by resources and difficulty in creating and sustaining multiple different versions of a program. Following review CAHS consider that there are other avenues to assist Aboriginal families who access the HWS through involvement with the CAHS Aboriginal Health Team and WACHS to better engage Aboriginal families. CAHS and WACHS are continuing to explore these avenues.

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