CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Finlay James Browne
Hearing dates:	17 – 20 October 2024
Date of findings:	10 May 2024
Place of findings:	Coroner's Court of New South Wales, Lidcombe, NSW
Findings of:	Deputy State Coroner, Magistrate Erin Kennedy
Catchwords:	CORONIAL LAW – mid-gut volvulus and bowel obstruction, ischaemic bowel, unconscious bias, consideration of disability and treatment in hospital, Bathurst Base Hospital, adequacy of care, NETS, provision of care to children in rural NSW
File number:	2018/17393
Representation:	1. Ms E Sullivan, Counsel Assisting the Coroner, instructed by Ms A Heritage (Department of Communities and Justice, Legal) 2. Ms A Horvath SC, for the Western New South Wales Local Health District and Sydney Children's Hospital Network, instructed by Ms K Hinchcliffe (Makinson d'Apice Lawyers) 3. Mr M Lynch, for Dr Gia Dan Ta, instructed by Ms B Versace (Avant Law) 4. Ms R Browne

Findings	***The identity of the deceased*** The person who died was Finlay James Browne. ***Date and place of death*** Finlay died on 10 December 2016 at the Sydney Children's Hospital, Westmead, New South Wales. ***Cause of death*** The cause of Finlay's death was a mid-gut volvulus and bowel obstruction, leading to ischaemic bowel and related complications. ***Manner of death*** The manner of death was natural (in the context of issues concerning the adequacy of the care and treatment provided in the emergency department of the Bathurst Base Hospital on 30 September 2016).

Recommendations	**<u>Recommendation 1</u>** **To the Western NSW Local Health District (WNSWLHD)** a. That the WNSWLHD consider the provisions of formal training to clinical staff on unconscious bias and how it influences clinical judgment, including as to persons with disabilities; b. Related to (1)(a) above, that the WNSWLHD consider the potential utility of Exhibit 3: the Australian and New Zealand College of Anaesthetists & Faculty of Pain Management – *Unconscious bias toolkit* for the purposes of such training, and consider preparing a similar 'toolkit' for use by clinicians within the Local Health District; c. That the WNSWLHD liaise with the Ministry of Health as to the review and revision process relating to the Policy Directive PD2017_001 *Responding to Needs of People with Disability during Hospitalisation* (January 2017) in relation to cognitive bias (noting the issues highlighted in these coronial proceedings); and d. That as a matter of priority, the General Manager of Bathurst Base Hospital formalise a clear escalation pathway for on-call executive hospital support in circumstances of a major clinical incident within that hospital (including where there are two urgent, competing surgical cases after hours); **<u>Recommendation 2</u>** **Jointly, to the WNSWLHD and Sydney Children's Hospital Network (SCHN), on behalf of the NSW Newborn & Paediatric Emergency Transport Service (NETS):** a. That the WNSWLHD collaborate with SCHN and NETS to ensure there is appropriate training for emergency department clinicians on an ongoing basis (given transient staffing arrangements), regarding: i. Policy Directive PD2023_019 *NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements* (August 2023); ii. The general availability of NETS to provide expert clinical advice and medical assistance for: 1. very sick or injured babies, children and adolescents up to the age of 16 years; or 2. patients aged 16 to 18 years with chronic or complex conditions who

	have not completed transition to adult health services; iii. The benefits of early contact with NETS in relation to very sick babies, children or adolescents; **<u>Recommendation 3</u>** **To the SCHN:** a. That there be liaison with the Ministry of Health as to the following matters being issues that deleterious on the provision of critical care services in children in New South Wales: i. Arrangements to ensure that NETS have priority access to a helicopter and fixed-wing aircraft; and ii. NETS to be resourced to provide sufficient teams to address the need of the child population noting that presently, five NETS teams rotate over a 24 hour period, compared to the previously instructed rotation of six NETS teams in a 24 hour period.
Non publication orders:	Nil

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BACKGROUND

1. Finlay James Browne was an extraordinary young man, and his loss at 16 has left a devastating impact on his family and friends. He set an example in his life that was inspirational to all of those who came into contact with him, and his example continues to inspire even after his passing. His life was cut short, and this inquest had the important task of exploring how and why that occurred.

2. Finlay was born on the 15 July 2000, the second eldest child of Rachel and Grant Browne. He was born with the genetic condition Trisomy 21. Finlay brought great happiness to his family and was adored by them. He was an active boy who enjoyed jumping on the trampoline, basketball, riding his bike, running, singing and dancing. He was treasured.

3. It was on 10 December 2016 at the Children's Hospital Westmead, aged just 16 years that he passed away. His family remained at his side, supporting and advocating for him in life and have continued to do so.

4. On 30 September 2016, Finlay was suffering from abdominal pain. His symptoms worsened and his mother, a registered nurse, decided it was time to take him to the Emergency Department at Bathurst Base Hospital.

5. What unfolded at Bathurst Base Hospital was a series of missed opportunities to properly recognise the signs and symptoms of the fact that Finlay was in critical danger. As a result of system errors and failures, it was not for many hours that Finlay's condition was identified, at which time things quickly escalated. Finlay subsequently underwent abdominal surgery to untwist his bowel around 12.15am on 1 October 2023. Finlay was transferred by a retrieval team to the CHW, arriving around 7am that morning. Further surgeries and complications ensued, and tragically, Finlay died on 10 December 2016, surrounded by his loving family.

FUNCTIONS UNDER THE CORONERS ACT

6. The primary function is provided by section 81 of the *Coroners Act 2009* (NSW). It is to make findings as to:

    a. the identity of the deceased;

b. the date and place of the person's death; and

c. the manner and cause of the person's death.

7. Pursuant to section 82 of the *Coroners Act 2009* (NSW), the Coroner may make recommendations in relation to any matter connected with the death. Recommendations relating to public health and safety are specifically mentioned in the *Coroners Act 2009* (NSW), as an example of the category of recommendations that might be appropriate.

NATURE OF THE INQUEST

8. The proceedings are inquisitorial in nature, not adversarial. It was not the function of this inquest to find negligence nor apportion blame. The proceedings are not criminal. In effect the proceedings were to explore the manner and cause of Finlay's death.

FAMILY STATEMENT

9. Finlay's family presented a very moving family statement. It was filled with images of his life, a few short but poignant words accompanying the images. Those images spoke volumes of a little boy filled with fun and mischief, love and affection. The joy he brought to his family was also evident in those photos, it was a powerful and beautiful reflection on his life, and an essential part of the inquest.

FACTUAL BACKGROUND

10. Those assisting me drafted a chronological summary of the key events available from the documentary evidence. This document was tendered and its content was agreed on by the parties following their contribution and those facts are now relied upon.

11. In his early years, Finlay was supported by a team of medical providers including a child health nurse, general practitioner, Dr Hal Rickard-Bell, paediatrician Dr Tim McCrossin, ear, nose and throat specialist Dr Andrew Wignell, ophthalmologist Dr Craig Donaldson, paediatric dentist Dr Sherene Alexander and cardiologist Dr Stephen Cooper. Dr Cooper was consulted due to Finlay having mild valve regurgitation.

12. Finlay experienced a lot of medical challenges throughout his life, but these were managed by his medical team and importantly by his parents. They knew his needs well.

13. At 9am, Finlay woke up and had a shower. He ate a healthy breakfast and conversed with his mother whilst watching YouTube clips on his iPad. He then ate morning tea at 11 am without difficulty.

Approximately 12.00pm - Finlay became unwell

14. At approximately midday, his mother noticed Finlay was suddenly unwell, she reflected that he had a strange look on his face, he got off his chair and laid face down on the tiled kitchen floor.

15. At about 12.30pm, Ms Browne led Finlay to the toilet and he opened his bowels. A large amount of soft brown faeces were noted. Shortly after this, Finlay began to dry retch and vomit.

16. After cleaning Finlay, Ms Browne gave him 1g of Paracetamol in tablet form. Finlay began to dry retch again. Ms Browne then ran a bath for Finlay and whilst in the bath, Finlay continued to dry retch and opened his bowels, Ms Browne noted a moderate amount of soft brown faeces which contained two red fragments that appeared to be capsicum. As Ms Browne stated in hindsight, the fragments were likely blood but she wasn't sure of this at the time.

17. At about 1.30pm, Ms Browne called Mr Browne, who was working in Orange, NSW. Mr Browne told Ms Browne that they had received a note from school last week about an outbreak of Norovirus. However, Ms Browne noted that Finlay had been off school for a week due to school holidays and that no one else in the family had been ill.

18. At about 1.45pm, Finlay was put into the shower so Ms Browne could clean the bath. Finlay laid on his stomach in the shower dry retching. Ms Browne commented that the 'noise was horrendous, he was very pale'. She began asking her younger daughter questions about what Finlay had eaten the day before. Her daughter repeated that 'he was fine'.

19. At about 2pm, Ms Browne took Finlay out of the shower and dried him. Finlay was taken to his bedroom and was momentarily settled. However he soon began to plead with Ms Browne for assistance and vomited bilious foul-smelling fluid that looked like faeces. Ms Browne lifted Finlay's shirt up to his abdomen and noted it looked distended. Finlay's abdomen was soft but he had particular pain on his right side below his ribs and above

the belly button. Ms Browne was concerned Finlay had a bowel obstruction but thought this was 'ridiculous' as he had opened his bowels.

20. At about 3.30pm, Mr Browne returned home and commented upon the smell entering the house. Mr Browne went in to see Finlay in bed and advised Finlay that they were going to the hospital. Ms Browne noted that Finlay was 'pale and his hands were cold and dusky in colour'. As the trio walked to the loungeroom, Finlay began dry retching again.

Approximately 4pm - Arrival at the Emergency Department, Bathurst Base Hospital

21. At approximately 4pm, Ms Browne and Finlay entered the Emergency Department (**ED**) of Bathurst Base Hospital (**BBH**). As the clerk took Finlay's details, he lay on the floor on his stomach.

22. At 4.33pm, Finlay was admitted to BBH. Between 4.33pm and midnight, 19 people, including Finlay, presented to the BBH ED.

23. It is understood that two Senior Medical Officers, two Career Medical Officer, one Junior Medical Officer and fourteen nursing staff were on shift within BBH Accident and Emergency at the time Finlay was admitted.

Approximately 4.34pm - triage by Registered Nurse Lauren Rodger

24. At approximately 4.34pm, Finlay was triaged by Triage Registered Nurse (**RN**) Lauren Rodger in the Triage room and assigned triage Category 3. This category required Finlay to be seen within 30 minutes. RN Rodger recorded that Finlay had a 'sudden onset of abdominal pain and vomiting…[a]pears distressed with the [nausea]'.

25. RN Rodger recalled that she took a history from Ms Browne and was advised that Finlay had 'abdominal pain and vomiting for approximately 4 and a half hours' and that there had been an outbreak of the Norovirus at Finlay's school. Ms Browne noted in her statement that she advised RN Rodger that Finlay has passed 'large amounts of formed soft faeces and the last time there had been blood in it'. RN Rodger stated that had it been reported to her that Finlay had been vomiting faeculent material, she would have noted this in her triage report.

26. RN Rodger noted Finlay was pale and tachycardiac. She did not take Finlay's blood pressure as at the time of triage Finlay as he was distressed with nausea and she did not 'want to cause any further distress' to Finlay, nor did RN Rodger physically examine Finlay's abdomen as the Triage room did not allow for a patient to lay down.

27. RN Rodger noted that based on her initial assessment, Finlay did not meet the criteria for the sepsis pathway in that he did not have a high temperature or a heart rate of more than 120, and all of his other vital signs were within normal parameters. RN Rodger assigned Finlay a triage category of 3 and he was put into the Rapid Assessment Triage Bed behind the triage area.

<u>Approximately 4.40pm – Finlay is assigned the Rapid Assessment Triage Bed</u>

28. At some point following Finlay's triage, a conversation occurred between RN Rodger and Nurse in Charge (**NIC**) Brendan Stapleton. NIC Stapleton recalled that Finlay had been allocated to the Rapid Assessment Triage Bed (which was normally managed by the Clinical Initiative Nurse (**CIN**)) until a bed became available in the ED. NIC Stapleton recalled that no concerns were voiced to him by either RN Rodger or Ms Browne. RN Rodger did not recall discussing Finlay with NIC Stapleton, however it was her usual practice to inform the NIC and the CIN when she allocated a patient to the Rapid Assessment Triage Bed.

29. At about 4.40pm, Ms Browne noted Finlay was pale, his hands were dusky and cool to the touch. She recalled that Finlay continued to vomit; both the noise and smell were horrendous and appeared to be faecal.

30. At approximately 5pm, Mr Browne attended the ED. Ms Browne advised him that Finlay was yet to be seen by a doctor. Mr Browne became anxious and stated that there were only a couple of people in the waiting room. Shortly after this, Mr Browne left BBH to check on their other children.

31. RN Rodger recalled that she did not have occasion to reassess Finlay as it was not part of her role to check that patients are seen by medical officers within their triage category timeframe. RN Rodger's evidence is that it was part of her role to re-assess patients if they deteriorated before being seen by the Medical Officer.

32. RN Rodger stated that Finlay was seen by a medical officer at approximately 5.15pm. A review of Finlay by Dr Aman Berry Williams, Junior Medical Officer (**JMO**) apparently occurred between 5.22pm and 5.44pm based on Dr Williams' interpretation of his own clinical record entry. In contrast, Campus Nurse Manager (**CNM**) Sandra Field recalled seeing Ms Browne and Finlay in the Rapid Assessment Triage Bed at about this time and upon noticing that Finlay 'did not look well', she asked an unnamed doctor to review Finlay. Ms Browne's evidence is that the conversation with CNM Field occurred after Finlay had been reviewed by 'the JMO'.

33. It is also noted that according to Ms Browne, CNM Field had asked Dr Ta to review Finlay at approximately 5pm, however it is accepted that this may have been a typographical error, and it may have been 6 pm.

<u>Around 5.22pm - Finlay is reviewed by JMO at the Rapid Assessment Triage Bed</u>

34. Between 5.22pm and 5.44pm, Finlay was reviewed by JMO Dr Aman Berry Williams. Dr Williams recorded in an 'ED Assessment Note' note at 5.44pm that Finlay presented with '5 hour history of nausea and vomiting', 'complaining of abdominal pain', 'Mother reports school has had a recent norovirus [outbreak]' and 'patient had 1 x episode of blood streaks in stool today'. On examination, Dr Williams recorded that Finlay's abdomen had 'some generalised pain, illicitied (sic) on palpation, nil guarding or peritonic features, mildly distended, bowel sounds ?reduced'. Dr Williams further noted that he 'Discussed with ED Senior Dr Dan Ta' and a plan was formulated for '1. CXR, 2. CT Abdomen, 3. Pain relief, 4. Anti-emetics, 5. Fluids'.

35. Dr Williams recalled that on assessment, Finlay was pale and tachycardic with a mildly distended abdomen, but 'appeared quite happy' and was 'otherwise hemodynamically stable'. Ms Browne recalled that she disclosed Finlay's history of faeculent vomiting to Dr Williams; in response, Dr Williams advised her to encourage Finlay to 'drink more'.

36. Dr William's usual practice was to discuss his assessment of patients with the consultant or Senior Medical Officer (**SMO**) to confirm a plan.

37. At approximately 5.45pm, Assisting in Nursing (**AIN**) Fleur Fitzell was asked by Ms Browne to get another emesis bag for Finlay. AIN Fitzell recalls seeing Finlay and his mother when Finlay was allocated to Bed 5 of the ED. AIN Fitzell recalls speaking to Ms Browne a few times during her shift, but does not recall Ms Browne saying anything in

particular to her about Finlay's condition. AIN Fitzell recalls that Finlay was 'vomiting at some point'.

38. At some time just before 1800 hours, Dr Ta's evidence is that he was made aware of Finlay when NIC Stapleton asked him to see Finlay.

39. Dr Ta physically examined Finlay. Ms Browne recalls advising Dr Ta of Finlay's abdomen being distended. Ms Browne's recollection was that this examination of Finlay by Dr Ta occurred whilst Finlay was allocated to the Rapid Assessment Triage Bed. Dr Ta's noted that on initial assessment of Finlay, the findings were consistent with a non acute (meaning non surgical) abdomen – that he had a soft abdomen with reduced bowel sounds.

40. Dr Ta says he discussed the case with Dr Williams and advised it was important to get bloods and possible imaging depending on the blood test results. Dr Ta recalls that he recommended trialling analgesia and antiemetics and giving a fluid bolus.

41. Dr Ta organised for Finlay to be moved to Bed 5 in the ED.

<u>Approximately 6pm – Finlay is admitted to Bed 5 of the ED</u>

42. At some time prior to or at approximately 6pm, Finlay was admitted to Bed 5 of BBH ED. RN Nicole Granger was assigned to Bed 5 during at this time.

43. Ms Browne says that on arrival at Bed 5, Dr Ta inserted an intravenous cannula into Finlay's right arm. Ms Browne also says that Dr Ta drew blood from Finlay at this time.

44. Ms Browne recalled that shortly after 6pm, Dr Ta explained Finlay was to have intravenous fluids and intravenous antibiotics.

45. RN Granger was advised by Dr Ta to administers an antiemetic and fluids to Finlay. At 6pm, intravenous normal saline 1L was commenced. Finlay was given Ondansetron 4mg intravenously at 6pm.

46. Around this time, after intravenous fluids were commenced, Ms Browne became aware that Finlay's lactate was 7 by a CMN. At 6.11pm, RN Nicole Granger recorded the following vital signs for Finlay:

Temperature	36.4
Peripheral Pulse Rate	91 bpm

Peripheral Pulse Rate Regularity	Regular
Blood pressure	105/81 mmHg
Mean arterial pressure	89 mmHg
Respiratory rate -	- brpm
Oxygen saturation	100% on room air
Blood glucose level bedside	11.6

47. This was the first time that Finlay's vital signs had been recorded since triage.

48. At 6.13pm, RN Granger recorded the following progress note:

> **Progress Note**
> Pt brought in by mum to bed 5 by EDMO with abdo pain and vomiting.
> A-PAtent maintaing own
> B- Spontaneous nil effort
> C- Pale in face sats 100% RA
> Child Hx of downs syndrome
> vomiting on arrival to bed.
> IVC inserted into right CF by EDMO TA with path collected
> IV antiemetic given as charted.
> IV F commenced as charted.
> Pt keeps asking mum for oral water but has vomited post oral water asked to attempt to keep NBM at this stage.
> Await further orders

49. At 6.18pm, Finlay was given Ondansetron 4mg intravenously. At 6.55pm, Finlay was given Ondansetron 4mg intravenously. At 7.05pm, Finlay was administered with Morphine 2.5mg intravenously and a second bag of intravenous fluid was commenced.

50. At some point whilst Finlay was in Bed 5, his Agilia pump was alarming. RN Carolyn Donaghy (who was not assigned to Bed 5) attended to Finlay's bedside to review the alarm. RN Donaghy observed Finlay crying and calling out, demanding a drink from Ms Browne. RN Donaghy recalls that Ms Browne was rubbing Finlay's back, "hushing him" and holding him. RN Donaghy believed the Agilia pump was alarming as Finlay had bent his arm which increased pressure and subsequently, the safety device shut off the flow of intravenous fluids. RN Donaghy recalls that she inspected the cannula site, repositioned Finlay's arm and then reset the pump. Finlay moved and bent his arm again, which blocked the tube and again active the pressure alarm of the pump. RN Donaghy suggested to Ms Browne that an arm board would be useful to hold Finlay's arm in an ideal position. RN Donaghy stated that Ms Browne informed her that she did not wish for RN Donaghy to apply an arm board to Finlay to stop him from bending his arm, or to manage his alarm.

51. An abdominal CT scan was ordered.

52. At 7.15pm, Finlay's vital signs were recorded.

53. At this time, Ms Browne advised RN Granger that Finlay's stomach was distended. RN Granger recalled conveying this information to Dr Ta and recorded such in a progress note at 7.16pm.

54. On-call consultant paediatrician Dr Samridh Nagar recalled that at 7:20pm Dr Daniel Tait, paediatric registrar, had attended the ED. Dr Nagar recalls that Dr Tait had informed the ED that that Finlay required surgical review prior to considering admission in the paediatric ward. Dr Tait was unable to see Finlay at that time as Finlay was having his CT scan.

55. At 7.25pm, Finlay was given Morphine 2.5mg intravenously and a Hudson mask was applied to Finlay's face when he tolerated it. His vital signs were: pulse rate of 82 beats per minute and his oxygen saturation was 97% on room air.

56. At 7:24pm, the abdominal CT commenced.

57. Around 7.25pm, RN Granger recalled that she took Finlay to the Radiology Department for his CT.

58. At 7.30pm, Finlay was administered with Morphine 2.5mg intravenously. Finlay's vital signs were recorded.

59. At 7.42pm, RN Granger recorded a further progress note which recorded that Finlay was given Analgesia as charted and was taken for a CT with 'mum escort', a Hudson mask for oxygen was used intermittently when tolerated.

60. At 8pm, Finlay underwent a CT scan of the abdomen. The CT was later reported on as follows:

> …
> Findings:
> There is evidence of mal-rotation. There is a swirling pattern and there is twisting of the SMA and the SMV consistent with a mal-rotation associated with the volvulus. There is oedema of the mesentery consistent with venous congestion. There is also free fluid in the upper abdomen particularly around the liver. No focal liver lesion. Spleen, pancreas, adrenals and the kidneys are unremarkable.

> CONCLUSION:
> Mal-rotation associated with the volvulus. There is an associated small bowel obstruction. There is oedema and free fluid. (ceacal mal-rotation).
> …

61. At 8.14pm, Finlay's vital signs were recorded. His pulse rate was 87 beats per minute and his oxygen saturation was 96% on room air.

62. At approximately 8.30pm, on-call locum general surgeon Dr Irandi Jayatilleke arrived at BBH after receiving a phone call from the Surgical Registrar, Dr Tania Lee, whilst at home in relation to a motor vehicle accident trauma patient who required urgent surgery (having a distended abdomen with intraperitoneal blood). Dr Lee, on-call Anaesthetics Registrar Dr Mandira Chakraborty and Anaesthetic Staff Specialist Professor Brendan Smith also assisted in this surgery.

63. At 8:53pm, the CT images were imported and available for viewing within the electronic medical record.

64. Around 9pm, Dr Jayatilleke and the other staff were prepping and scrubbing for surgery upon the MVA trauma patient, who was being intubated.

65. Dr Lee wrote the following retrospective note (on 19 October 2016, being 18 days after the event) in relation to events occurring from approximately 9pm onwards:

> Written in retrospect regarding events on 30/9/16
>
> I was not consulted about Finlay until approximately 2100 on Friday night as I was in theatre with the general surgeon locum on call Dr Jayatilleke preparing for and emergency laparotomy. In the consult I was informed that this patient had a finding of sigmoid volvulus on CT scan and to review and that the patient was haemodynamically stable at that point in time. I informed Dr Ta that I was about to scrub in for an emergency laparotomy and that the formal report for the CT needed to be chased and that I would come down and review the patient after the laparotomy. Following that I consulted the surgeon on call and we reviewed the films from the computer in theatre. Realising that the patient had abnormal anatomy and evidence of volvulus, we contacted the radiologist on call for an urgent CT report which demonstrated malrotation and small bowel vovulus.
>
> Following this finding Dr Jayatilleke personally called the paediatric surgical registrar on call at Westmead Childrens and explained the situation (and also the fact that his abnormal anatomy required and

specialised fixation procedure to prevent further volvuluses which Dr Jayatilleke was unable to perform) and they had accepted care of the patient. Following this, as the trauma laparotomy patient was going off to sleep, Dr Jayatilleke asked me to review Finlay in ED to assess his observations and examine his abdomen to look for signs of decompensation. At that point in time approx 2130, I went down to ED and informed Dr Williams that we had discussed the patient's case with the paediatric surgical team at Westmead that that they had accepted care and to organise urgent transfer with NETs. I also reviewed Finlay and saw that he was haemodynamically stable and alert at that point in time with a distended abdomen with no obvious evidence of peritonism.

Following the review, I proceeded back to theatre and scrubbed in for the laparotomy.

Towards the end of the first case, there were a couple of phone calls from ED and NETs regarding Finlays status and the anaesthetics registrar proceeded to go down to review the patient as Dr Jayatilleke and I were unable to. We were later informed that Finlays BP had dropped and that he was very unwell at which point in time Dr Jayatilleke unscrubbed in the middle of the case to review him downstairs whilst I finished with the first case.

She later returned and informed us of his status and we organised to proceed with a second laparotomy on Finlay as soon as the first case was off the table which was at approximately 1230am. Throughout the laparotomy Finlay was relatively stable and the findings of the laparotomy was as documented in the operation report. During the operation Dr Jayatilleke also discussed findings with Dr Katherine Langush the paediatric surgeon on call at Westmnad childrens to inform her of the findings and obtain advice on the next best step of action.
…

66. Consistent with this, the following 'Addendum' progress note (recorded by Dr Williams at 9.05pm) states:

> CT Abdo reveals caecal malrotation with volvulus
> Discussed with Surgical Registrar Tania,
> - Unlikely patient will be able to be managed at BBH
> - Need to contact WMH paediatric surgery to arrange transfer

67. Dr Jayatilleke requested that Dr Lee review Finlay whilst she commenced surgery on the trauma patient, Professor Smith requested Dr Chakraborty to also review Finlay.

68. At approximately 9.30pm, Dr Lee attended ED to review Finlay. Dr Tait was also present in the ED at that time. Dr Lee told Dr Williams that the surgical team had spoken with

Westmead Children's Hospital and that urgent transfer would need to be arranged. Dr Lee observed that Finlay was awake and agitated; his observations in the clinical records appeared okay; 'he was haemodynamically stable and alert. There was no obvious evidence of peritonism'; on examination, his abdomen was soft. Dr Lee then returned to the operating theatre and scrubbed in (for the MVA patient's surgery).

69. At approximately 9.20pm, Dr Williams discussed Finlay with Paediatric Registrar Dr Daniel Tait. Dr Williams recalled that Dr Tait stated that the medical issues to be aware of with Finlay included his renal function, blood sugar level and sleep apnoea. In the following 'Addendum' progress note Dr Williams wrote at 9.21pm:

> Discussed with paediatric medical registrar Dr Dan:
> Medical Issues to be aware of
> - Monitor renal function
> - Blood Sugar
> - and Sleep apnoea - chronic CO2 retainer according to blood gas

70. It appears that at this time, Dr Tait discussed with Ms Browne, Finlay's CO2 levels and the possibility that Finlay had sleep apnoea.

71. Dr Jayatilleke states that upon Dr Lee returning to the operating theatre, Dr Lee reported that Finlay's vital signs were stable, although he was in pain and had a distended abdomen, all consistent with caecal malrotation/volvulus. Dr Jayatilleke states: 'I was in the unusual and unlikely scenario of having an urgent surgical procedure for a bleeding elderly patient, and Finlay who need[ed] surgery was well. I estimated that the elderly's lady's trauma laparotomy could potentially take me about 1.5 to 2 hours. I needed to sequence the cases'.

72. Dr Jayatilleke says that she realised there was a chance (given Finlay was 'haemodynamically adequate' at the time, and that she had no choice but to operate on the bleeding elderly patient) that Finlay could be transferred to the Children's Hospital at Westmead in the time that it took her to complete the surgery for the bleeding, elderly patient.

73. Dr Jayatilleke 'immediately rang the Paediatric surgical team on call at CHW' and explained the situation. Dr Jayatilleke notes her understanding that: 'they agreed it made sense to transfer Finlay to CHW because he needed urgent surgery', however this depended on how quickly transfer could be arranged, so which surgical team [Bathurst

or CHW] could operate on Finlay first. Jayatilleke asked for a retrieval team to be organised immediately, and asked to speak with the retrieval team to explain the plan and the acuity. Dr Jayatilleke recalls that the retrieval team that became involved was Newborn & Paediatric Emergency Transport Service (**NETS**), that she spoke personally to the NETS team and they agreed to the transfer. Dr Jayatilleke then proceeded to operate on the elderly MVA patient.

74. Dr Kusel recalls that the ED doctor (Dr Williams) who initially contacted her was coordinating Finlay's care but was being directed by the surgical team at BBH, who were in theatre dealing with an unrelated trauma case, and that the surgeon (Dr Jayatilleke) did not feel confident managing Finlay at Bathurst and/or performing a Ladd's procedure at BBH, as it is commonly a paediatric surgical procedure.

75. Following this call, Dr Kusel spoke with Dr Catherine Langusch, Consultant Paediatric Surgeon at CHW seeking advice at to the most appropriate surgical management of Finlay and where that surgical management ought to occur. It was agreed between Dr Kusel and Dr Langusch that Finlay required urgent surgery being a laparotomy, devolving and Ladd's procedure. However, they were concerned about the estimated and/or potential transfer times involved in transferring Finlay from Bathurst to Westmead. Following this call, Dr Kusel contacted NETS at 9.57pm (see [84] below).

<u>Between 9.30pm- 9.50pm – Handover occurs</u>

76. At approximately 9:30pm, RN Granger provided a handover of Finlay to the night staff and requested that a full set of observations be taken from Finlay. RN Denise McGuire assumed care of ED Beds 1, 2 and 3 during the night shift and Enrolled Nurse Denise Hodges assumed care of ED Beds 3, 4, 5 and the Special Care room; also working were RNs Kathy Hamilton and Robyn Berry.

77. At some time after 9.30pm, CNM Lynette Sloane contacted BBH's 'executive on-call', Bradley Molenkamp. CMN Sloane recalls that she contacted Mr Molenkamp to notify him of Finlay's condition. CMN Sloane cannot recall the content of the conversation with Mr Molenkamp, just that she believes that the conversation occurred after she had spoken to NETS.

78. Mr Molenkamp recalls that CMN Sloane told him that a 16 year old patient, Finlay, was unwell and needed surgery at Bathurst (though the locum surgeon had indicated that

she wasn't comfortable with this) or that he needed transfer and had been accepted to Westmead Children's Hospital but that NETS weren't willing to transfer Finlay because of his age.

79. Mr Molenkamp recalls that he instructed CNM Sloane to instruct the SMO to call NETS in order to prioritise the transfer and that if there was an 'absolute refusal' from NETS to transfer, then it may have been necessary to arrange for an adult retrieval team. Mr Molenkamp told CNM Sloane to call him back if the situation was unable to be resolved. He was not contacted again after this initial call (nor did he make any further calls in relation to the matter). Mr Molenkamp states:

> 'The fact that there was a locum surgeon at the Hospital that night meant that none of the usual surgical staff were available. If necessary a call could have been made to the local surgeons to determine if any of them were available'.

80. This was the extent of Mr Molenkamp's involvement.

81. Around 9.50pm, RN Granger handed over care of Finlay (in Bed 5) to EN Hodges. During that handover, EN Hodges was informed that Finlay 'had Down syndrome and had been admitted to the ED earlier that day with a possible volvulus of the stomach'; he was 'nil by mouth; combative at times and had been removing his monitoring equipment which made it difficult to record his vital signs.' When EN Hodges assumed care of Finlay, she observed that Finlay was crying and in distress, asking his father for lemonade on a number of occasions; he was moving in bed and his facial expressions suggested he was in pain; he appeared tachypneic (rapid breathing) and diaphoretic (sweating heavily).

82. EN Hodges recalls that she attempted to take Finlay's vital signs (although there was no monitoring equipment attached as he had removed it). With the assistance of Finlay's father, Finlay was persuaded to allow his blood pressure to be taken: the first reading (automatic) was 82 systolic. The second and third (manual) readings were 72 systolic and 70 systolic, respectively. Following this, EN Hodges immediately called out for a medical officer. EN Hodges moved Finlay's bed into the corridor and also called out to RN Hamilton to inform her of Finlay's deterioration. RN Hamilton and EN Hodges transferred Finlay to Resus Bay 2. EN Hodges recalled that a medical officer was unhappy with her decision to relocate Finlay and asked EN Hodges if she 'even knew how to take a BP'.

83. RN Hamilton then assumed care of Finlay after he was transferred in the Resuscitation Bay and EN Hodges had no further involvement in his care or treatment.

<u>9.57pm – First NETS call</u>

84. At 9.57pm, the first NETS conference call was initiated by Dr Kusel and lasted for 29 minutes and six seconds. The participants (at various points in time) were: Dr Amanda Kusel, Surgical Registrar, CHW; Dr Kathryn Carmo, NETS consultant and Acting Director of NETS; Dr Aman Williams, the intern JMO of BBH; Dr Catherine Langusch, Consultant Paediatric Surgeon, CHW; and Dr Samridh Nagar, Paediatrician, BBH.

85. The call commenced with Dr Kusel seeking to arrange transfer for Finlay to the CHW after the BBH surgeons performed a laparotomy and devolving procedure. Conservations about Finlay's weight, age, whether he was known to the CHW and whether there were any intensive care beds available were had. Dr Carmo advised that an adult retrieval team would be needed for Finlay. The following is an extract:

Dr Carmo:	What's ... what's the lactate?
Dr Kusel:	It was 7.2. But I also know from talking to the general surgeon there, that general surgeon didn't sound particularly confident with that. I kind of feel like this is going to have to become consultants talking to each other about what…
Dr Carmo:	Yeah, yeah. Sure, sure.
Dr Kusel:	... and I feel a little bit like I don't know what the best thing is for the child.

86. Dr Williams and Dr Catherine Langusch, surgical consultant and CHW, were added to the call between Dr Kusel and Dr Carmo.

87. Throughout the conversation, Finlay deteriorated and his blood pressure dropped to 70/40. Dr Williams was advised by Dr Langusch to 'mobilise the most senior people [he] can in the department' to assist in Finlay's care. Dr Samridh Nagar was added to the 'NETS call'. It was also stated to Dr Nagar '… we need someone there senior who's going to be able to help direct traffic, because he needs to get his volvulus un-volved as soon as possible.' Dr Nagar was also advised '… he needs to be in theatre quickly. His bowel's dead or dying'. Following this, Dr Williams left the call to assist with Finlay and Dr

Langusch remarked that Dr Williams 'sounded like … he might be getting a … bit out of his depth'.

88. Towards the end of the call Dr Carmo stated '…I'm just going to let the Medical Director know that it's a bit of an impending doom situation with ...'.

About 10pm – Finlay is transferred to Resus Bed 2

89. Around 9:45pm – 10:00pm, Finlay was moved to Resus bed 2 as he had deteriorated (see [82] above). Dr David Mutasa (a Locum ED Medical Officer) became involved in Finlay's care, and was given a hand-over by either Dr Ta, Dr Williams or both.

90. At 10pm, Finlay was given Fentanyl 20mcg intravenously.

91. At approximately 10.12pm, there were attempts to insert a nasal gastric tube. One attempt was successful; however, Finlay pulled the tube out. At some point during the attempts, Ms Browne told RN McGuire to 'just do it Denise'. Dr Chakraborty attended, quickly reviewed Finlay's notes and then intervened. She asked that Finlay's blood pressure, pulse and heart rate be measured. After three attempts, Finlay's blood pressure remained 'unrecordable'. At that point, Dr Chakraborty asked that Finlay be moved into the resuscitation area and that the paediatric registrar be called to assist.

92. At 10.12pm, Finlay's vital signs were recorded as follows (almost two hours since his last reading):

Pulse rate	98 bpm
Respiratory rate	18 brpm
Blood pressure	70/42 mmHg
Mean arterial pressure	51 mmHg
Oxygen saturation	92% on room air
Blood glucose level bedside	7.4

93. Finlay's blood pressure was not further documented until 11.28pm.

94. Dr Chakraborty directed that Finlay be given 1 litre of Hartman's solution intravenously. Shortly after this, it became clear that Finlay's cannula had 'tissued' (that is, IV fluids were not entering his veins); IV fluids were immediately stopped.

95. Dr Chakraborty called Professor Smith to advise him that her impression that Finlay was in severe hypovolemic / septic shock because of the volvulus (based on his agitation, that he had no urine output, an unrecordable blood pressure and increased lactate in

the context of CT Abdomen which showed a volvulus). Dr Chakraborty advised him that Finlay needed emergency resuscitation and access to achieve this, but that his agitation was a barrier; he required ventilation/intubation and an anaesthetist with expertise in children's airways. As Professor Smith was caught up in the trauma laparotomy, he suggested Finlay be administered with 150mm of intramuscular Ketamine to sedate Finlay. (At 10.48pm, Finlay received 150mm of intramuscular Ketamine).

96. At some time around 10.15pm or 10:30pm, Dr Kathryn Carmo called on-call consultant paediatrician Dr Samridh Nagar. Dr Nagar recalled Dr Carmo saying words to the effect: 'the child needs urgent surgery which will have to be done at Bathurst Hospital and the surgeon is busy with another patient in the theatre'.

97. Following the call, Dr Nagar made his way to BBH ED. Upon arrival, Dr Nagar reviewed Finlay's clinical notes and called to request Dr Jayatilleke for an urgent surgical review.

<u>About 10.45pm – Finlay is transferred to Resus Bed 1</u>

98. Around 10.45pm, Finlay was transferred to Resus Bed 1.

99. Paediatrics Registrar Dr Daniel Tait recorded a retrospective note on 10 October 2016, being 10 days after the event, in relation to events occurring from approximately 10pm onwards. He stated:

> …
> Asked by paediatric consultant (Dr McCrossin) to document my involvement in Finlay's case.
> Paediatric team was not formally consulted until 2200hrs on the 30/9/16
>
> I became aware that Finlay was in ED earlier in the evening through watching FirstNet from the paediatric offices.
>
> Finlay had a history and examination that was consistent with a surgical issue and I thought he should be seen by the surgeons before leaving ED.
>
> I spoke with the Paeds nursing staff (Jo) after seeing that he was going to be admitted under us and was made aware that a bed was booked for Finlay under Dr Nagar on the paeds ward. I went to ED (about 1920hrs) to ensure he did not come to the ward without a surgical review. I spoke with Dr Williams (ED intern) in person after I saw the blood results however Finlay was not reviewed by me as he was already in the CT scanner.

> I returned to ED about 40min later when the CT images came through to ensure that a surgical review was being undertaken. It was then I spoke with his mother about the extra medical concerns (acute on chronic renal impairment, OSA, and high BGL). The surgical registrar was in the department and reviewing Finlay as I left. I was then called to ED at approx 2200hrs to help with his treatment as he had become combative with the insertion of the NGT and needed sedation and intubation for safety. I met up with Dr Nagar on my way to ED who was also called in to help. He was noted to be hypotensive and moved to Resus 1 for fluid resuscitation and intubation and ultimately transfer to the OT. I departed ED with Dr Nagar at approx. 2330.
> …

100. Around this time, Dr Chakraborty was managing Finlay's airways. Dr Tait attempted to cannulate Finlay and experienced difficulty. Dr Chakraborty requested the ED SMO who was present (believed to be Dr David Mustasa), to take over management of Finlay's airway so she could insert a large bore cannula. Dr Chakraborty requested Finlay be given Tazocoin, however this does not appear to have been administered. During this time, Finlay was given Noradrenaline.

101. At approximately 10.45pm, RN Robyn Berry was asked to be a scribe during Finlay's resuscitation. She recorded that Finlay was moved to a resuscitation bed to insert a nasal gastric tube, five staff and Ms Browne were present. The progress note further records that 'security not called at this stage at mothers request'. As the resuscitation continued, it was noted Finlay was 'very combative'.

102. At 10.48pm, Finlay was given Ketamine 200mg intramuscularly. (This appears to conflict with the advice regarding Ketamine provided by Professor Smith and RN Berry who recorded she was told *'150 micrograms of ketamine were administered*').

103. According to RN Berry, at 11.05pm, a surgeon arrived from the operating theatre who had spoken to NETS and would perform an emergency operation on Finlay, who would then be sent to the CHW.

104. Dr Nagar wrote the following retrospective note (on 12 October 2016, being 12 days after the event) regarding events occurring from approximately 10.30pm onwards:

> …
> I [received] a call from NETS consultant on 30/09/16 at 10:30 pm
> I noted that there was no documentation of paediatric role in the progress notes till 10/10 and therefore adding now

> The request from NETS was unlear but I understood that the expectation was for me to be present in ED immediately and help transfer of Finlay (Downs syndrome with volvulus)
> I was informed that he will need the initial devolving surgery at Bathurst hospital by general surgeon who was busy with another surgery (for truma related bowel perforation)
> I came to the ED immediately and informed Dan, Registrar to immediately come to ED as well and also discussed about this child with him
> On arrival at ED , Finlay was agitated and his BP was fluctuating between normal to low
> Anesthetic registrar was in attendance and was arranging sedation and decided to start Noradrenaline and intubate , ventilate
> I called the surgeon in the OT about Finlay who was busy in other surgery and was almost finishing and coming to ED as she mentioned
> …
> The blood gases revealed metabolic acidosis
> The intern in the ED also tried contacting Orange surgeon for devolving as the theatre here was busy
> By then the surgeon had arrived in ED who I met and she discussed with the mother about the need for surgery
> ABC was being taken care of by the anesthetic reg in ED while logistics were arranged by the Afterhours nurse and ED staff to transfer Finlay to OT for surgery
> I noted later that blood gases improved and surgery (devolving was done by the surgeon at Bathurst) and Finlay was transferred to Westmead for further surgery
> I noted after discussion with the Surgeon at Bathurst hospital next day that [Finlay] underwent resection of large parts in intestine and these events of abdominal pain (malrotation/volvulus) appeared to have been recurrent and chronic

<u>10.51pm – Second NETS call</u>

105. At 10.51pm, the second NETS conference call occurred, lasting for 8 minutes. The participants (at various points in time) were: Dr Kathryn Carmo; Dr Aman Williams; Dr Nipu Jayatilleke; CNM Lynette Sloane; Coordinator of the Aeromedical Control Centre; Clinical Coordinator of NETS; and Lauren, the BBH Switchboard Operator.

106. During this call, Dr Carmo was advised by Lauren, the BBH switchboard operator, that she was not able to put her in touch with the Medical Director of BBH and could only put her through to the CNM.

107. Dr Carmo then spoke with CNM Sloane, and was in effect managing Finlay from the call, informing the hospital of a major incident occurring, being told there was no surgeon to do the surgery, and noting that the information was that the surgeon could not complete

the surgery. She enquired whether there was another surgeon available to complete the surgery, but was told there was not.

108. Following this discussion, at 11.03pm, Dr Carmo is patched through to the NSW Ambulance Aeromedical and Medical Retrieval Flight Service (**AMRS**) Control Centre to organise a retrieval team. The call ended with Dr Carmo asking who the Aeromedical Consultant was on shift.

109. At 10.55pm, RN Berry noted Finlay's heart rate was 82 bpm and his respiratory rate was 20.

110. Around 11.02pm, RN Berry recalls that Finlay had deteriorated further and that she was told that his blood pressure was unknown due to other interventions being carried out.

111. Around 11.05pm Dr Jayatilleke arrived in the ED to assess Finlay in Resus 1 and discussed the need for surgery with Ms Browne, whilst Dr Lee completed the surgery on the MVA patient. Dr Jayatilleke states that she was 'surprised and disappointed to find [Finlay] was still in the ED' and recalls that she requested that Finlay be brought to the operating theatre.

112. Shortly after 11.05pm, Dr Jayatilleke called the on-call paediatric surgeon at CHW, Dr Catherine Langusch, and confirmed that the surgery would be performed at Bathurst. Dr Jayatilleke asked if Dr Langusch could be available on the phone if any paediatric surgical advice was required intraoperatively, which Dr Langusch agreed to. Dr Langusch recalls that during the conversation with Dr Jayatilleke, they discussed aspects of the operation. The pair discussed the type of surgery Finlay required – namely, an urgent laparotomy to untwist the bowel to restore blood flow. Dr Langusch advised that Dr Jayatilleke was not required to do a full Ladd's procedure, but that untwisting the volvulus was the priority and that this needed to be done prior to transfer. Amongst other matters, the plan to leave Finlay's abdomen open for transfer to the CHW was discussed.

113. At 11.06pm, RN Berry was informed that Finlay's lactate was 10.9.

114. At 11.09pm, the third AMRS call occurred. This was a call between 'Ben' and 'Michael' to check the weather conditions to ascertain if a helicopter could be flown from Sydney to Bathurst.

115. At 11.10pm, RN Berry was advised by the anaesthetics registrar that Finlay was experiencing hypovolemic shock.

116. At 11.12pm, the fourth AMRS call occurred. This call was between Ben and Michael, who confirmed that due to turbulence and clouds, a helicopter could not assist in retrieval.

117. At 11.14pm, the fifth AMRS call occurred. This call was between Larissa and Dr Carmo, who relayed the information that a helicopter from Sydney was unable to fly into Bathurst because of the weather. Discussion was had regarding road transport, but they would need to travel from Sydney to retrieve Finlay as the Orange road team was already 'out'.

118. At 11.15pm, the sixth AMRS call occurred. The call was initiated by Larissa who contacted Dr Carmo and advised that she would call and put through the Aeromedical Consultant, Peter.

119. At 11.16pm, the seventh AMRS call occurred. This call related to Larissa contacting AMRS Consultant Peter and advising him that he was about to be patched through to Dr Carmo.

<u>11.17pm – Third NETS call and eighth AMRS call occurred</u>

120. At 11.17pm, the third NETS conference call occurred and lasted for 10 minutes. This was the first time that AMRS Consultant Peter Clark and Dr Carmo spoke directly. The participants were: Dr Kathryn Carmo; Dr Peter Clarke, the adult aeromedical co-ordinator; and Dr Una Nic Ionmhain, the AMRS retrieval doctor.

121. This call concerned the tasking of retrieval medical services. Dr Carmo was advised that helicopters could not be used due to the weather and that a fixed wing plane would be required. A plan was formulated for a fixed wing plane to travel from Sydney to collect Finlay and for the AMRS team to contact BBH for further conference calls. Dr Carmo informed Dr Clark that 'Yeah, we did try and get in touch with those... all those people but I think Bathurst is having a little bit of an overwhelming time themselves at the moment'.

122. At 11.25pm, Dr Williams recorded an 'Addendum' progress note which noted that he had discussed Finlay with Dr Kusel, Dr Langusch, and Dr Carmo. The plan was for BBH to

perform the de-volving procedure and following this, Finlay would be retrieved and transported to the CHW.

123. At 11.25pm, 11.26pm and 11.27pm, AMRS telephone calls occurred. These were in relation to attempting to locate a fixed wing plane to travel to Bathurst to retrieve Finlay and that Dr Ionmhain would be at the airport 'within the hour'.

124. At 11.28pm, the AMRS retrieval flight was tasked, being flight 68508. At this time, Finlay's vital signs were recorded and thought to be sufficiently stable to transfer him to the operating theatre.

125. AMRS Dr Una Nic Ionmhain recalls that around 11.30pm, she was contacted in relation to Finlay for the first time. She recalled the following handover:

> 16 year old male with trisomy 21 with caecal volvulus on CT with lactic acidosis with haemodynamic instability. Urgent laparotomy underway in Bathurst Base Hospital with plan to retrieve to Westmead Children's Hospital post op.

<u>11.38pm - Finlay taken to operating theatre for surgery</u>

126. At 11.38pm, Finlay was admitted to the operating theatre.

127. At this time, Dr Williams ceased care of Finlay but remained at BBH until Finlay was transferred to the CHW. Dr Nagar also ceased care for Finlay and departed the ED of BBH.

<u>1 October 2016 – Finlay remains in surgery</u>

128. At 12.02am, Dr Ionmhain arrived at the AMRS base at Sydney airport. At 12.08am, the eleventh AMRS call occurred, involving 'Adam', Peter Clarke, and Dr Ionmhain. The purpose of this call was to speak to a someone at BBH to ascertain Finlay's condition. At 12.09am, ED Registrar 'David' joined the call and advised that Finlay had left the ED and was in theatre. Registrar David commented in the context of inserting the nasal gastric tube, 'obviously he's got ADHD and it was difficult to manage. So it was challenging he was having long standing obstructive sleep aponia', 'he was getting agitated from the abdominal pain and also not tolerating the [nasal gastric] tube that well and he was vomiting the plan was to try and get the child intubated so that we could secure the airway.

129. At 12.15am, Finlay was given Tazocin 4.5g. Between 12.15am and 12.20am, surgery commenced on Finlay. Dr Jayatilleke states that she:

> … performed an exploratory laparotomy and devolved the malrotation. I found caecal malrotation with purulent, free fluid in the abdomen, malodorous with evidence of ischaemic bowel from proximal jejunum to hepatic flexure with volvulus around the superior mesenteric vessels. Congenital adhesions were carefully divided, and bowel mesentery devolved.
>
> Despite the initially catastrophic appearing findings, I was very pleased to see that the application of warm packs created good initial response, with peristalsis noted all the way to the ileum; the distal ileum had occasional peristalsis. The caecum and early part of the ascending colon was not viable and also looked suspicious for perforation.
> …
>
> I was determined to save as much bowel for Finlay as possible, and actually applied warm packs for about 45 minutes to his bowel During this time, I called Dr Langusch and explained the findings and my plan to take the minimum length of bowel required tonight, as I was really hoping the peristaltic segments would have some viability. She agreed with my plan.
>
> I was therefore able to limit Finlay's resection to the caecum and part of the ascending colon (essentially a very limited right hemicolectomy). I left him with an open abdomen with a V AC dressing on the abdominal incision, as he would need a "re-look" laparotomy some hours later as well.

130. Dr Lee recorded an operation report at 2.21am, echoing that of Dr Jayatilleke's report above.

131. At 12.42am, the retrieval aircraft, 'AMQ' departed from the Sydney AMRS base.

132. At 12.45am, RN Debbie Marsden recorded a progress note that Finlay's IV lines were in situ, with norad infusion and Hartmanns running,

133. At 1.25am, the retrieval team landed at Bathurst airport.

134. At 1.43am, the retrieval team arrived at BBH and saw Finlay at 1.50am, who remained in the operating theatre. A handover was provided by Professor Smith to Dr Ionmhain.

135. At 1.50am, tissue was collected from Finlay for Pathology testing. The Report recorded the following diagnosis 'CAECUM:- ISCHAEMIC NECROSIS OF THE TERMINAL ILEUM, CAECUM AND COLON'.

136. At 3.09am, RN Marsden recorded a progress note advising that Finlay was transferred to CHW by air.

3.10am - The Retrieval team met with Finlay at BBH

137. By 3.10am, the retrieval team had their first 'patient contact' with Finlay in the operating theatre. Dr Ionmhain examined Finlay and recalls that her impression was:

> Volvulus with ischaemic bowel with evolving haemodynamic instability and SIRS/ cytokine storm and large fluid shifts/ losses - already resected and washed out with ABx. At present ventilation and kidneys ok.

138. During Finlay's transfer to the CHW, Dr Ionmhain stated that Finlay became profoundly unwell. A phone call was made to CHW to prepare infusions for Finlay.

139. According to medical notes, at 4.45am, Finlay was discharged from the operating theatre. This is in conflict with flight nurse RN Anita Zovic's recollection of events - she noted Finlay and the retrieval team departed BBH at 4.12am, and handwritten notes on the AMRS Plan Brief. Whilst the Procedure Case report notes a discharge time of 4.45am, it lists that the anaesthesia was stopped at 4:12am and lists the 'Patient Out Room' time as 4.12am.

140. At 5.12am or 5.13am, the retrieval aircraft departed Bathurst.

5.27am – Finlay arrives at Sydney airport

141. At some time after 5.27am, the retrieval aircraft landed in Sydney (after an approximate 15 to 37 minute flight). A road crew arrived at Mascot Air Ambulance base to transfer Finlay to Westmead Children's Hospital at 5.40am.

142. At 5.30am, Dr Mandira Chakraborty recorded a handwritten note (as reproduced per A/Professor Luke Lawton's interpretation) which provides that she became involved in Finlay's resuscitation:

> …
> Upon my arrival:
> ED staff were trying to insert NGT – Finlay was needing to be held by mum & 3 other staff.
> NGT successful, however Finlay pulled it out.

At this point, I intervened (NGT not a priority, no recent BP/vitals had been assessed for some time).
BP unrecordable over 3 x attempts.
I asked for 1L Hartmanns stat however the only one IVC was tissued.

Called Prof Smith with my impression:
1. Severe Hypovolaemic shock: agitated, no urine output, [increased] lactate
2. Finlay needed emergent access to resuscitate him – however agitation the main barrier & therefore needs intubation/ventilation?

Prof Smith suggests (as he was currently caught up in OT & unable to help with intubation/ventilation) 150mg ketamine IM for adequate sedation
…

6.55am - Finlay arrived at CHW

143. At 6.55am, Finlay and the retrieval team arrived at CHW. He was admitted under the care of on-call general surgeon Dr Gordon Thomas and was commenced on vasopressin; Finlay had been given a total of 11L of IV fluid, and still remained acidotic.

144. Following Finlay's arrival at CHW, he then underwent surgery performed by Dr Thomas. The Operation Sheet operative findings were recorded as follows:

(i) dusky purple midgut with areas of questionable viability, oedematous +++ - on very narrow mesenteric stalk.
(ii) stapled ascending colon also questionable viability
(iii) ~ 30cm from DJ pink viable jejunum
(iv) rest colon viable
(v) foul smelling haemoserous fluid.
(vi) small bowel easily re-volving

145. Following the surgery, Finlay was admitted to the Paediatric Intensive Care Unit (**PICU**).

2 October 2016 – Day 2 – Finlay was taken to theatre

146. On 2 October 2016, just after midday, Dr Thomas performed a laparotomy, reassessment of bowel, evacuation of haematoma and application of VAC dressing.

147. Finlay was commenced on a Heparin infusion for further reperfusion of the bowl and Total Parental Nutrition (**TPN**) via his central line.

3 October 2016 – Day 3 – Finlay remained in PICU

148. On 3 October 2016, Finlay remained in PICU. It was noted his abdomen was 'looking more distended in the morning' and had dry Vac dressing with no fresh bleeding.

4 October 2016 - Day 4 – Finlay was taken to theatre

149. At 10am on 4 October 2016, Finlay went into theatre. Dr Thomas performed a relock laparotomy, resiting of jejunostomy and reapplication of VAC dressing.

150. Following return from theatre, Finlay's care was escalated as part of the Clinical Emergency Response Systems (**CERS**) in place at the PICU. This occurred after each post-operative period for Finlay.

5 October to 6 December 2016 – Finlay remained in CHW

151. From 5 October to 6 December 2016, Finlay remained admitted at the CHW. During this time he underwent multiple surgeries and medical imaging procedures; and experienced high temperatures and infections. On 11 October 2016, a biopsy of Finlay's peritoneal tissue was taken and on 13 October 2016, a biopsy report was prepared, which identified that both the ileum and ascending colon showed evidence of necrosis involving at least the mucosa. Finlay was extubated twice on 25 October 2016 and 2 November 2016. Further scans on 10 November 2023 revealed evidence of non-specific diffuse bowel inflammation in the pelvis but no significant occult pelvic focal infections/collections have been identified. From 10 November 2016, Medical Director of the Intensive Care Unit, Dr Nick Pigott, became involved in Finlay's care. On 21 and 22 November 2016, JMOs Rajkumar Abhinav and Emma Turner noted that Finlay's hot spots in bowel and fevers were likely secondary to bowel necrosis.

152. From 1 to 6 December 2016, Finlay battled metabolic acidosis; his kidneys were failing and he required more blood transfusions. He was commenced on Hydromorphone to manage his pain and required substantial medical support.

8 December 2016 - Day 69 - Finlay remained in PICU

153. On 8 December 2016, a multidisciplinary team meeting occurred to discuss Finlay's current condition and prognosis. Dr Piggott recalled that Finlay's parents were concerned about Finlay's quality of life. Ms Browne and Mr Browne ultimately decided on palliative care.

10 December 2016 – Day 71 – Finlay passed away in PICU

154. At 1.30pm, Ms Browne told Finlay that he was going on a great adventure and she was there to take him home, he double nodded and mouthed 'yes Mum'. Shortly after this, Finlay was extubated. Finlay passed away approximately an hour later.

155. When Finlay left the PICU at CHW, staff from the PICU lined the corridor to see him off, as a tribute to him and as a gesture of respect.

156. Finlay then returned to Bathurst, for some final time in his home together with his family.

DELAY IN CORONIAL INVESTIGATION AND INQUEST PROCEEDINGS

157. These proceedings took place over seven years after relevant events. In December 2017, Ms Browne requested that the State Coroner assume jurisdiction over the matter. On 11 October 2019, a three-volume brief of evidence was submitted by the officer in charge, Detective Senior Constable Buck Cunich; shortly after, the NSW Department of Communities and Justice, Legal, were instructed to assist the Coroner.

158. Ms Browne gave evidence at the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (**the Disability Royal Commission**) in 2020. During 2020 and 2021, investigations in this matter continued including the briefing of experts, and the obtaining of a complete set of medical records. In 2022, the matter was listed for hearing in May 2023; unfortunately, due to the unavailability of both Counsel Assisting and the then Coroner, the matter was re-allocated and listed for hearing in October 2023.

159. The effect of delay on the family must be acknowledged. The significant delay inevitably impacted the quality and reliability of the evidence.

ISSUES

160. To assist in focusing the inquest, an issues list was created which included the following:

    1. Whether the care and treatment provided to Finlay Browne at BBH on 30 September 2016 was adequate and appropriate. If not, whether any failings affected the ultimate outcome. Relevant issues in this regard include:

a. The availability of senior staff, including a qualified emergency physician to oversee Finlay's care;

b. Whether there was delay or failings in recognizing and prioritizing two patients (Finlay and another patient) with urgent and concurrent needs for major surgery.

c. The availability of appropriate senior executives to provide urgent additional resources or support for BBH (including surgical staff);

d. Whether the care and treatment provided to Finlay at BBH Emergency Department was affected by his disability (being Down Syndrome, Autism, and moderate intellectual disability)

2. Whether communications involving the NETS as to Finlay's retrieval from BBH were adequate and appropriate

3. What steps have been taken by BBH and the WNSWLHD, and NETS in relation to any lessons learned from Finlay's death, and whether those steps are adequate? Whether, having regard to (3) above, any recommendations are necessary or desirable in connection with Finlay's death

CARE AND TREATMENT AT BATHURST BASE HOSPITAL

Evidence

Ms Rachel Browne (Finlay's mother)

161. At the time of Finlay's presentation to the ED at BBH, Ms Browne was a nurse with over two decades of experience, including as Nurse Unit Manager and also a Clinical Nurse Educator. This was of significance in these proceedings, as Finlay's mum was not a usual lay parent. She was able to bring a higher level of understanding to the situation, she was acutely aware of procedure and proper practice in hospitals, and this showed in the level of detail and observations that she was able to share with the inquest. She in fact worked at the very hospital at which they attended.

162. Ms Browne provided a very comprehensive statement during the coronial investigation dated 13 August 2018, she also took certain contemporaneous notes whilst at BBH, and made further notes during Finlay's stay at the CHW. Additionally, Ms Browne's

statement dated 2 February 2020, and evidence to the Disability Royal Commission on 19 February 2020, were included in the coronial brief tendered into evidence.

163. The evidence of Ms Browne as to key events on 30 September and 1 October 2016 has been incorporated in the above factual background.

164. Ms Browne also gave evidence at the inquest on Tuesday, 17 October 2023. She did not leave her son's side from when they entered the ED around 4pm until Finlay was taken to theatre which was after midnight.

165. The evidence was very clear that Ms Browne was a diligent, careful and measured parent. She waited a reasonable time at home to see if he could recover, and when it became clear that he wasn't recovering, she took him to the hospital She had every reason to believe that it was not a bowel obstruction, given he had been eating and had also been able to use his bowels.

166. When at hospital she did not expect nor demand any special treatment as an employee of that hospital. She raised her concerns with the staff at the hospital in a timely manner, and passed on all relevant information. She could have done no more. She was not playing the role of a nurse at that time, but instead she was a mother, fearfully concerned for the wellbeing of her beautiful son.

167. After hearing her evidence, reviewing the statements and brief material she did more than could be expected or anticipated from any parent in the circumstances. She was fully supported by Finlay's father Mr Browne, and her other children throughout.

168. Ms Browne's evidence related to a number of specific areas of concern relating to treatment. Ms Browne remained measured and thoughtful in her evidence. I accepted her recollection of events, she was the witness who watched all events as they unfolded. She took careful notes, and has refreshed her memory many times over the years, and it is clear these events have continued to replay in her mind. What was very striking about her account was the objectivity that she was still able to bring. Her evidence was thorough, with attention to detail that highlighted that the added benefit of being a health care professional, and Ms Browne did her best to recount events without judgment or accusation.

169. She recalled that after Finlay was triaged, he was taken to a cubicle which is known as a 'quick consult bed' that was behind reception in the corridor, and not a usual bed within the ED. She noted that it was busy with people moving to and from the entry of ED, and they were in a position not actually visible to the triage nurse station. Ms Browne was increasingly agitated and anxious about Finlay's condition, and was trying unsuccessfully to catch the gaze of anyone who walked past however no observations were taken during this period.

170. This was of greater concern where a child was involved, and in particular a child with special needs. Finlay was able to communicate well generally, and could be well understood by his family, but it must be recognised that he had greater limitations and as such it was critical that he was being watched carefully.

171. She also explained that given Finlay's "invisible" disability in the form of autism, he was sensory defensive regarding his head and mouth, and required time to process information, to have autonomy and some things needed to be explained to him carefully, impacting on the way nursing staff interacted with him. Ms Browne noted that the reference in notes and evidence to Finlay being "non-communicative" was very much incorrect with Ms Browne feeling that she knew the real state that he was in, she knew her son and she knew that what he was displaying was consistent with a critically unwell child. She said the following:

> I knew he was in clear and present danger and I - I knew, at that time, that he was possibly going to die. And I voiced that concern to her, and she said, "Don't be silly, Rachel. Don't be silly. He's not going to die"

172. And further:

> I think that what's happened here is that there's a heavy use of trisomy 21 by the health professionals that dealt with Finlay that day and I think there was a lot of labelling, unfortunately, that occurred. At no point in time did anyone seemingly think to ask me, his mother, how Finlay communicated, what his ability to understand was. In fact, Finlay had a very good ability to understand spoken word. He did have some hearing deficits but, you know, in his earlier years, we went through a lot of years with the Shepherd Centre before he turned five so he could use his residual hearing correctly. Finlay did sign. We, as his family, didn't sign to him because he made up his own sign language, so it was not often very accurate. He would respond appropriately to questions asked, however, and by no means was our son nonverbal.

173. Ms Browne had noted the brown vomit that stank and smelt to her faeculent, and Finlay was vomiting when he was triaged, and also in front of Dr Williams. Ms Browne had also mentioned to Dr Williams that Finlay was vomiting brown stained fluid but observed that this didn't prompt additional action. She was also concerned that no staff were documenting or recording Finlay's fluid output given how much he had vomited and because he was cannulated and receiving fluids, but not urinating. Finlay was also complaining of thirst which Ms Browne knew to be a marker of hypervolaemia. Ms Browne recalled being made aware of Finlay's lactate level of 7.2 mmol/L shortly after 6pm from CNM Sandra Field and from her clinical background, she knew that any reading over 4mmol/L had a mortality rate of 27%. She knew at this point in time that her son was critically unwell.

174. The only clinicians who reviewed Finlay were Dr Williams in the quick consult bed, and also Dr Ta, who examined Finlay's abdomen and inserted an intravenous cannula, however there were no further reviews until Finlay was moved. Hours went by, and they must have been very long hours for Ms Browne and Finlay.

175. After Finlay was brought back from the CT scan, they were taken back to bed 5; Ms Browne indicated that nobody was liaising with her, as Finlay's mother, about the plan for him.

176. Around 8pm, Dr Tait came to Finlay's beside; there was a discussion, several minutes at best, and Dr Tait referred to Finlay's CO2, or carbon dioxide, was high and was demonstrating that he had sleep apnoea; Dr Tait had said he was watching Finlay on FirstNet and was concerned that he would be sent to the paediatrics unit; she could not recall discussion about the volvulus. Ms Browne recalled the surgical registrar being in the ED shortly after 8pm, speaking with Dr Williams but did not involve herself nor Finlay in that discussion:

> Dr Ta, shortly after 7.30, had come out and was directly opposite the doors of the plaster room which is in view - the end of the bed that Finlay was in and he said something like, "They're incompetent. There's no - they have no sense of time management. He has a malrotation and caecal volvulus. He needs to go to Sydney." He crouched down on the ground. He had his hands up his head and then I said, in fact, "You're going to get him out of here. You're going to get him out of here, aren't you?" And Dr Ta walked off. I didn't see him again over the course of that presentation.

177. Ms Browne stated the following views as to her assessment of the care and treatment provided to Finlay:

> I know that having a child with a disability, I'm privy to witnessing unconscious bias, labelling, diagnostic overshadowing, which I think the events of 30 September, particularly in the chronology display, in statements, in comments by all clinical staff, even up until the very end when it was recognised how acutely unwell my son was, there were still excuses made as to why he was behaving like that or why he was exhibiting these signs and symptoms, and this, unfortunately, impacted what care and treatment he was going to get on that day.
> …
> I think that there was time lost, there were moments lost, there was the ability for just one person to realise how sick he was and try and advocate for us to get him the help he needed, and it did not happen, and I've been angry and sad for six and a half years because I know as a clinician that nobody goes to work to try and have an adverse incident happen on their shift. As clinicians, we go to work because we provide service. We provide service to the community, we provide service to people who we may live with and work with, and we do this because we love our jobs, and we care about what we're doing, and I feel sorry for the people involved in Finlay's care on that day that this happened. But they are accountable and everybody played a part in what happened in Bathurst Emergency Department on 30 October 2016. And for 16 years I've fought hard for my son to be recognised as a human being and receive the same basic care that we all deserve.
>
> And I have had to fight for a further six years to be here today because if I hadn't continued the fight like so many, this would never have seen the light of day, and I only hope that from our family coming here today that Western New South Wales Local Health District can review this, can, hand on heart, say that there are changes to be made and that is not to apportion blame to clinicians because that is not going to work. There needs to be open and courageous communication going forward for this unfortunate turn of events to actually result in something positive.

178. Ms Browne also gave evidence as to numerous examples of what would be labelled unconscious bias in the treatment that Finlay received including staff rolling eyes upon seeing Finlay prone on his stomach on the ground, and being placed in a less visible consult room. She also recalled that the discussions were with her initially, and Finlay was in part ignored, and assumptions had been made that he was non-verbal. It is important to record and recognise these concerns raised by Ms Browne. Each matter individually may be explained away, but Ms Browne attended as a parent of a child with challenges, and had lived experience with him. She explained that part of her reluctance

to take Finlay to hospital was because she felt she knew the added challenge that she would face getting him treatment.

179. Ms Browne's comment to the CNM as to her concern Finlay would die was a verbal REACH in respect of which there was no proper escalation of care or medical review as should occur. Significantly, Ms Browne told the Court that there was nobody advocating for Finlay, taking the lead or communicating a plan. She stated:

> I felt unseen, I felt like my child was less than, I felt there were assumptions being made about what he was vomiting and perhaps it - because he was - had a diagnosis of Down syndrome that maybe - that's what it smells like when people vomit because no one was raising any concern about that.

180. The evidence of Ms Browne was brave, accurate and impressive. Watching a mother talk with such clarity and resilience and speak about this tragic and difficult event with such dignity, left no one hearing that evidence untouched. There was no doubt that she continued to do so in memory of Finlay, and for the benefit of others to come.

Dr Aman Berry Williams (JMO, ED BBH)

181. Dr Aman Williams was a first year intern and there was only he and Dr Ta as medical staff on duty that afternoon within the ED.

182. He first saw Finlay sometime between 5.22pm and 5.44pm and he took a history from Finlay and Ms Browne. He stated:

> I took a history from Finlay and his mother. I was told that Finlay had experienced nausea and vomiting for approximately 5 hours. He had been unable to keep down solids and fluids and complained of abdominal pain. Finlay's mother said that there had been a recent outbreak of norovirus [a type of virus that causes gastroenteritis, with vomiting and diarrhoea] at Finlay's school. Finlay's mother said that Finlay had had one episode of blood streaks in his stool that day.
>
> On assessment Finlay was pale and tachycardic but otherwise haemodynamically stable. On examination, Finlay had some generalised pain upon palpation of his abdomen but no guarding. His abdomen was mildly distended. Dr Williams considered that Finlay "appeared quite happy / comfortable at the time" of his initial assessment.

183. In oral evidence, Dr Williams did not recall there being any faeculent smell in the room Finlay was in, nor being told of faeculent vomiting by Ms Browne. He believed that he

would have documented anything of clinical relevance or concern, but agreed that there was a chance he missed it although was also of the view that it would be surprising if he had done so.

184. Dr Williams' usual practice was to assess a patient and to present that assessment to the consultant senior on the floor, to confirm a plan and proceed accordingly. Consistent with this, Dr Williams' evidence was that he discussed Finlay's presentation with Dr Ta and the plan included taking a venous blood gas test.

185. In his statement, Dr Williams stated: "Once the venous blood gas test was performed at approximately 1800 hours and revealed a lactate of 7, I immediately reported this to Dr Ta. An elevated lactate can be indicative of an ischaemic process". In oral evidence, Dr Williams agreed he did not have a clear recollection of this. However, he confirmed his understanding and even as a junior doctor it was known to him that a lactate of 7.0 can reflect quite a serious pathology, for example ischaemia or issues with blood supply.

186. Dr Williams' noted: "Dr Ta did not appear to be particularly worried about the lactate". Dr Williams statement noted that after this lactate reading, a "plan was put in place for Finlay to undergo a chest x-ray and CT of the abdomen". Dr Williams made an additional entry of 'ADDIT – Lactate 7.0' to a clinical record timestamped at 5.44pm. It was not clear when this entry was made.

187. In oral evidence, although having no recollection of the interaction, Dr Williams agreed it was possible he informed Dr Ta of the lactate result closer to 7pm; however, he noted the capacity of the i-STAT machine to provide a "result effectively immediately", and said it would not be uncommon for him to wait for the results at the bedside of the patient.

188. Dr Williams referred to ordering the CT scan of Finlay's abdomen at approximately 7pm noting that clinical records indicate the time was around 7.04 pm. Dr Williams stated that he would not have ordered a CT scan on his own accord and would have ordered it because Dr Ta requested that he do so.

189. Dr Williams referred to learning about the result of the CT of the abdomen at approximately 9.05pm and that it revealed a caecal malrotation with volvulus. Dr Williams believed that he would have looked at the report, because he could not interpret the CT scan at that time. Dr Williams recalled that the result was discussed

with Dr Ta, as well as the surgical registrar, Dr Lee. Dr Williams states: "I was told that the operating theatre at the Hospital was unavailable, and it was decided that Finlay should be transferred to another hospital for management".

190. Dr Williams had never arranged transfer of a patient before, he called Orange Hospital and the CHW for assistance. He also recalled that he asked Dr Ta for assistance on a number of occasions. However, it was his recollection that at some point, Dr Ta finished his shift and left the Hospital without informing Dr Williams. Dr Williams could not recall the response to his requests for assistance and agreed that he felt out of his depth in managing Finlay at that point.

191. At 9.20pm, Dr Williams discussed Finlay with the paediatric registrar, Dr Daniel Tait, who raised certain medical issues to be aware of including renal function, blood sugar level and sleep apnoea. Around 10pm, Finlay deteriorate and Dr David Mutasa the ED Career Medical Officer (**CMO**) who took over from Dr Ta became involved in Finlay's care.

192. Dr Williams' shift concluded at 9pm, but he did not leave until Finlay was transferred. In oral evidence, Dr Williams stated:

> I had an understanding that [Finlay] had a very serious pathology, and this is the first I'd ever been involved in such a serious case. I know my shift finished at 9pm, and I was so worried about the situation that I stayed on until 5.30 in the morning until he was flown out. So yes, I did understand that this was a serious matter.

193. As to whether he could have done anything differently, Dr Williams told the Court, after extending condolences to Finlay's family that his practice had been significantly moulded by his experience with Finlay. As a vascular surgeon he ensures that he works closely with his junior doctors and teams, and works closely with the families. He ensures that they are supported and well informed through the process. He has remained conscious of the need for support for services.

194. Dr Williams gave helpful evidence, he tried to assist the inquest although was limited by the age of the matter and recollection of events that occurred many years before. From his own evidence he was a very new doctor, he was not aware of NETS and he had never been required to organise a patient transfer for treatment in another hospital.

195. Dr Williams is a now an experienced doctor and was reflecting on his experience with the benefit of that. His involvement and treatment was as a very junior doctor. In many

ways he was limited by the level of supervision, or in this case the lack of it. He was able to reflect on what would have been done better, how important patient and family communication is together with the need to work together as a team within the hospital. It was telling that he remained with Finlay until he was airlifted, well beyond the expiry of his shift.

Dr Gia Dan Ta (SMO, ED BBH)

196. Dr Ta was the SMO with the responsibility of the initial treatment and diagnosis of Finlay. He recalled the patient number was high that day, and that he was busy and multi tasking many patients. Some of those patients initially presented with higher seriousness and had been triaged 1. The other SMO, Dr Nguyen, was dealing with a motor vehicle patient who was taken into surgery requiring urgent laparotomy.

197. As to the nature of his role, Dr Ta initially stated that he was "involved on the periphery, due to the concerns of nursing staff with Finlay Browne's progress". He initially suggested that the ED was not structured in a way to allocate a JMO to a particular team, but in evidence he accepted that he was the team leader of Dr Williams.

198. Dr Ta recalled first becoming involved in Finlay's management when he was approached by the afterhours CNM Sandra Field who asked him to assess Finlay. She wasn't happy with Finlay's progress, and asked Dr Ta to have a look at him. CNM Field said the paediatric registrar had already been consulted and there was a plan to have Finlay "Fast Tracked" and admitted to the paediatric ward, with the paperwork already prepared. This was a system in place between the paediatric and emergency departments where paediatric patients with suspected gastroenteritis who failed fluid trials (and so could not be discharged home) were transferred to the paediatric ward.

199. Dr Ta recalled that he examined Finlay and took a history. A significant matter in the inquest was that there were no records made by Dr Ta in the electronic medical records, although he had a recollection of entering details on the system. In evidence, Dr Ta told the Court after thinking about it, the only explanation was that he may have accidentally recorded the entries into another patient's notes, or forgotten to save such records. He first became aware there no clinical entries from him in Finlay's medical record around one or two years later, when there was a complaint referred from the Health Care Complaints Commission.

200. Dr Ta then assessed Finlay and formulated a plan to cannulate him and to draw blood for investigations. Dr Ta inserted an IV cannula and obtained a blood sample. Dr Ta's initial assessment was that the findings were consistent with a non-acute abdomen which was soft with reduced bowel sounds. Those findings did not indicate that a surgical intervention would likely be required.

201. He discussed the case with Dr Williams, and advised the next steps. He proposed trialling analgesia noting it was important to get bloods and possible CT imaging depending on bloods results. Noting:

> I advised trialling analgesia as the patient was non communicative and exhibiting behaviour which was not necessarily typical for pain, so a trial was appropriate, and antiemetics, and giving a fluid bolus. I organised for the patient to be moved from a cubicle behind the Triage area to Bay 5 in the Emergency Department acute ward for this to be done.

202. In evidence, Dr Ta recalled that he reviewed Finlay earlier than 6pm, probably about 5.40pm, Finlay was vomiting, or dry retching. Dr Ta could not recall the smell of the cubicle or whether it smelt like faeculent vomit. In evidence, Dr Ta stated that when Finlay was moved to Bed 5, he did not appear to need analgesia at that time, as "he wasn't – wasn't able to indicate whether there was pain anywhere". In hindsight, Dr Ta conceded that he may have underestimated Finlay's pain, and that agitation from Finlay may have been because he was in pain.

203. Dr Ta also accepted that he should not have referred to Finlay as non-verbal, and that what he had intended to express was that Finlay simply wasn't verbalising at the time.

204. As to the results of the VBG test, Dr Ta stated that the time stamp on the VBG was 6.01pm and he asked Dr Williams to chase Finlay's results. Dr Ta recalled returning to see Finlay around 7pm, and approaching Dr Williams who was at the doctor's station, "chatting to another doctor"; he asked for the results of the VBG and other blood tests; Dr Williams then checked the computer at advised that Finlay's lactate was 7.2mmol/L. In oral evidence, Dr Ta stated:

> So, when I asked him he looked at the - quickly looked at the computer and told me the result that the lactate was 7.2, and I just basically repeated it to - to make sure that I wasn't hearing wrong, and then that's when alarm bells start to ring.

205. After being advised of the lactate level, Dr Ta requested that Dr Williams order the CT scan. He recalled:

> … walking up to the radiography department to tell them that we've got an acute abdomen. We need - we need an urgent CT. I was just trying to speed things up. Otherwise, things don't happen.

206. Dr Ta agreed that this indicated a situation of clinical urgency, and that "in the context of abdo-distension, vomiting, signified to me some sort of bowel ischemia". In his statement, Dr Ta stated that the sepsis pathway did not need to be initiated, given Finlay's other observations were between the flags including a normal temperature and because there are other causes of a high lactate. This position was maintained in evidence, but Dr Ta ultimately agreed that in retrospect some antibiotics could have been given and that initiating the sepsis pathway would have had the concurrent benefit of increased monitoring of Finlay. Dr Ta also conceded that on the basis of Finlay's lactate level, a rapid response should have been called once he was aware of the lactate.

207. In evidence, Dr Ta could not recall whether the conversation with Dr Lee occurred over the telephone or in person and he could not recall the specifics about the lactate, but had some recollection of giving Dr Lee the advanced warning about the lactate whilst Finlay was being sent for CT scan.

208. In his first statement, Dr Ta recalled that he handed over the CT abdomen results to the surgical team around 7.40pm more than 1.5 hours before a formal report was available. He initially believed that this was as soon as the CT was done, and he saw the images, even though the radiologist had not formally reported on the images.

209. Dr Ta relayed his opinion noting caecal volvulus, to the surgical team. He did not have an opinion on transferring Finlay from the hospital at that point, understanding he would be seen by the surgical and paediatric teams as the surgical registrar did not convey her intention to transfer the patient when first informed of the caecal volvulus "almost immediately" after the CT scan was done".

210. In his supplementary statement, Dr Ta said:

> On hearing the VBG of 7.2, I immediately ordered a CT abdomen. At that time I felt guilty that I had not followed up the VBG result personally, and felt that I should expedite the CT. I walked over to the

> CT department and told the radiographer there was an acute abdomen needing an urgent CT abdomen. The CT request was time stamped 1915.
>
> I hovered in front of the computer screen used for viewing X-Rays and CT scans. The images of Finlay's CT became available for viewing in ED at around 1940, although the radiologist's report on the findings was not available until after 2100, when I went off duty. The CT showed a volvulus, however, I was not able to identify the anatomical point the twist originated from.
>
> I contacted the surgical registrar by phone at around 1940 to advise her of the volvulus. The Registrar was in the operating theatres at the time, but not scrubbed. The Registrar had access to the CT images but told me to wait for the formal report. I told the Registrar that it was obvious on the imaging that there was a dilated loop of bowel, and we did not need the formal report. The Registrar repeated her plan to wait for the formal report. Given the finding of volvulus, it is inconceivable that I would not have immediately contacted the surgeon when I viewed the imaging.

211. In evidence, Dr Ta stated that as he was viewing CT scan images at a computer terminal in the ED, he rang Dr Lee from the telephone at the terminal, and told her "we've got a – a caecal volvulus on a CT". Dr Ta described being "laughed off", as Dr Lee gave an "incredulous response". Specifically, Dr Ta stated:

> And the - the response was, she - I think I was - I hate to say it, I thought I was being laughed off. And - and I said, "Look, you can have a look the images yourself. You - are you near a terminal?" And then she looked at it, some silence, and then - and then I - and then she said, "Can you - have - have you got the report?" I said, "No, but," I said, "You don't need a formal report to see that it's - it's a surgical abdomen. It's a - a volvulus." And - and - and - and I was told to - to chase the report, despite that.

212. Dr Ta said this was a five to ten minute conversation, and that he was frustrated with the response of Dr Lee. Dr Ta agreed he could have contacted the consultant surgeon to raise the issue, or have spoken to the retrieval service.

213. A few things arose from this evidence. The significant disadvantage Dr Ta faced in his recollection was the lack of contemporaneous notes taken by him. Although he recalled taking notes there is no evidence that this occurred. Although he did not review the facts of the case until the matter was raised by the Health Care Complaints Commission one or two years later, it is remarkable that given the ultimate outcome for Finlay that he did not consider the situation of the notes or lack of them in closer proximity to the

events of the night. It also seems incongruous that he would not have taken notes had he received such an incredulous response to the information he relayed to Dr Lim. He was also seemingly recounting that particular version of events for the first time in evidence, after previously providing a statement.

214. In any case, there are no notes and Dr Ta now relies on memory some six years later. Although Dr Ta appreciated the clinical urgency of the situation, and that time was of the essence and on his account Dr Lee had ultimately agreed there was "some kind of volvulus" it remained the case on his evidence that there was no immediate plan. Dr Ta was asked to chase the report by Dr Lee, although the wait might have been an hour or longer. Dr Ta agreed that he could have contacted the radiologist to get an urgent report. There is no real explanation given the urgency of the situation that there wasn't an immediate coordinated approach to care for Finlay.

215. The evidence of Ms Browne supported and in part corroborated that of Dr Ta. She noted that Dr Ta was distressed by the events after he became aware of the lactate reading. she described him in detail, crouching down with his head in hands, lamenting what was unfolding and failure to act by others.

216. However Dr Ta also acknowledged that he could have expedited matters, he could have pursued the CT with vigour, and if dissatisfied with the response of Dr Lee, gone directly to the surgeon. Dr Ta acknowledged the shortfalls.

Hand-over to Dr Mustasa

217. At 9pm, Dr Ta handed over Finlay's care to Dr Mustasa and Dr Williams was also present. Dr Ta reported that Finlay had a caecal volvulus, was haemodynamically stable, that the surgical registrar was aware and they were awaiting the formal report from the radiologist. At this time the formal CT report was still not available, although Dr Ta states that he had checked on its availability when he could.

218. In his initial statement Dr Ta was asked whether he "identified any systemic issues that needed to be addressed". He responded that this matter had "highlighted the difficulty that occurs when patients with special needs arrive in hospitals that may not have the facilities and workforce resources to manage them. It is very sad and frustrating for the staff, the patient and the family". When questioned, Dr Ta advised that he thought there "should have been more staff dedicated and more – more frequent examination".

219. In his later statement, Dr Ta stated:

> In relation to Finlay's management overall, with the benefit of hindsight, I acknowledge that there are several things I could have done better. There was a delay in getting the VBG and I really wish I had followed this up earlier. I also accept that as the more senior doctor, I should have supervised Dr Williams more closely.

220. Dr Ta accepted that he should have called NETS straight away, or that Finlay should have been transferred to a nearby hospital, such as Orange. He agreed he ought to have paid more attention to the sepsis pathway. Dr Ta agreed that this matter had had a profound impact upon him as a clinician.

221. The evidence supports that Dr Ta was stretched in his own capacity this night. At the time clarity seemed to be lacking in the status of the JMO and who they reported to. There seemed on his account to be poor communication with the surgical team, and no clear plan on a pathway to get an urgent patient out of the hospital and to a place where they could, in a situation like this, get emergency surgery.

222. It was clear upon receipt of the lactate levels at the latest around 7.00pm Finlay was in trouble, and significant trouble. It was clear that at this point urgent action should have been taken to facilitate the CT and prepare for a likelihood that surgery would be required.

Dr Taina Lee (Surgical Registrar, BBH)

223. Dr Lee was a surgical registrar at BBH. She had worked the day shift but was called back to BBH at around 6pm or 7pm to assist with the patient who had a perforated bowel and required urgent surgery.

224. In oral evidence, Dr Lee said that she was in the ED around 7.30pm to review the surgical patient. She could not recall any discussions whilst in the ED at this time regarding Finlay. Dr Lee's memory was that she first became aware of Finlay in the ED after scanning for potential patients through the FirstNet software system. Dr Lee accepted that records indicated she had first accessed Finlay's medical records at 6.17pm using FirstNet which can be accessed from any computer within the hospital. In part this access of records remained unexplained. At that time the lactate result was available potentially, and possibly sits with Dr Ta having raised issues mounting with Finlay.

225. Dr Lee told the Court that as she had not been consulted to review Finlay, and that it was not uncommon for patients in emergency to have high lactates, therefore not necessarily prompting review of the patient. For a surgical registrar to become involved in the care of an ED patient, a formal request was required by ED medical staff to the surgical team. At this point there had been no such request.

226. Dr Lee, in her statement referred to first being consulted about Finlay by Dr Ta at approximately 9pm, and Dr Lee had no recollection of being consulted or spoken to by Dr Ta in the ED before 9pm. At this time, Dr Lee states that she was already in theatre, and the MVA patient was being anesthetised. She recalled Dr Ta stating that Finlay's CT images showed evidence of sigmoid volvulus and that the patient was hemodynamically stable, but required a review. In evidence, Dr Lee did not recall Dr Ta informing her that Finlay's lactate was over 7mmol/L. Dr Lee and Dr Jayatilleke then reviewed Finlay's CT images on the computer in the theatre; she was told the radiologist had been called to urgently report on the CT findings. In her clinical notes, Dr Lee recorded: "Realising that the patient had abnormal anatomy and evidence of volvulus, we contacted the radiologist on call for an urgent CT report which demonstrated malrotation and small bowel volvulus".

227. In oral evidence, Dr Lee explained that as the condition of malrotation is quite uncommon, Dr Jayatilleke was concerned that Finlay would need to go to the CHW for a special procedure, and contacted the on-call paediatric surgical registrar at the CHW, Dr Amanda Kusel, who accepted care of Finlay.

228. At approximately 9.30pm, Dr Lee attended the ED to review Finlay at that time, she told Dr Williams that the surgical team had spoken with CHW and that an urgent transfer would need to be arranged. Dr Tait was present at this time.

229. Dr Lee performed a "focused examination" of Finlay to assess if he was haemodynamically stable and whether there were any signs of overt peritonism, which may have indicated perforation. Dr Lee noted that Finlay was awake and agitated. His observations in the clinical records "appeared okay", and he was "haemodynamically stable and alert"; there was no obvious evidence of peritonism, he did not have guarding or rigidity of the abdominal wall, his abdomen was soft on examination. In evidence, Dr Lee explained that she formed the view that Finlay was haemodynamically stable and alert because he was alert when she examined him, and also, because he was connected

to bedside monitoring. Noting the poor clinical records, Dr Lee agreed that "if the blood pressure had not been taken for over two hours before I saw him, then I wouldn't have necessarily thought that that would have been consistent with him being haemodynamically stable". Dr Lee was not sure how much time she spent examining Finlay, but stated that it was not her normal examination as she had to get back to the other operation.

230. Dr Lee recalled that whilst in the ED, she saw Dr Tait and although unable to say for certain, believed the timing was just prior to starting the laparotomy.

231. Dr Lee then returned to the theatre and scrubbed in for the MVA patient's operation. During that procedure, calls were received from ED and the NETS about Finlay which were taken by theatre staff and the anaesthetist and anaesthetic registrar.

232. At one point, Dr Lee recalled that there was a call that Finlay's blood pressure had dropped and that he was very unwell, at which point, the anaesthetic registrar went down to the ED and reviewed Finlay. Subsequently, Dr Jayatilleke unscrubbed in the middle of the MVA patient's operation to review Finlay, whilst Dr Lee finished with the MVA patient. She returned and informed the team of his status, and they organised to proceed with Finlay as soon as the first case was off the table.

233. At around 12.30am, Finlay's procedure began Dr Jayatilleke was on the phone to the paediatric surgeon at the CHW during the operation. The part of Finlay's bowel that had died was resected.

234. Dr Lee first entered clinical notes into Finlay's records on 19 October 2016, although she made detailed contemporaneous operation notes.

Response to Dr Ta's recollections

235. Dr Lee did not agree with Dr Ta's recollection of events.

> Because part of my normal practise is that a CT scan is important in diagnosing a patient, and there are many certain instances where we would wait for a CT scan before proceeding with the decision for management. But I would never - I would never tell a doctor that, you know - if he told me that the patient was unwell and needed to be reviewed immediately, I would have gone down and seen the patient, and I would not push having to wait for a CT report, because a CT report is important, but it's not the deciding factor, and my job is not to decide

> whether the patient is - is an emergency operative candidate. My job is to review the patient and speak to the consultant about it, and it's her job to make the decision about what needs to be done.

236. Dr Lee also considered it unlikely that the conversation with Dr Ta occurred prior to 8pm given her recollection of being in the theatre with Dr Jayatilleke at the time.

237. Although Dr Lee prepared a contemporaneous operation report on 1 October 2016, she agreed that her retrospective clinical notes of the review of Finlay made on 19 October 2016 ought to have been documented earlier.

238. Reflecting back on the events, Dr Lee stated the following:

> … one of my regrets is that… my recollection of my interaction with Finlay's mum was not a long period, and I wish I had spoken to her more about what was happening. I feel that at - at that time, I wasn't a hundred per cent sure about what Dr Jayatilleke's thinking was in regards to her decisions in - in regards to transfer, and things like that, and I wasn't sure about - I did not know much about malrotation. He was the first and only patient I've seen with malrotation throughout my career, and I - I was not aware of the Ladd procedure also, so - but my biggest regret is that I did not spend a bit more time possibly speaking to her about what our current plan was at that time, and – not documenting in the notes at that time is - is something that I have changed since then.

Dr Daniel Tait (Paediatric Registrar, BBH)

239. Dr Tait was working as a paediatric registrar at BBH.

240. Dr Tait stated that he first became involved with Finlay around 7pm when he noticed whilst doing paperwork, that Finlay had been incorrectly admitted under paediatrician, Dr Samridh Nagar, as he was of the view that further investigation was needed. Dr Tait then attended the ED and observed Finlay with Dr Williams and Dr Ta present. Dr Tait said that based on the available information it appeared that Finlay's presentation looked to have a surgical cause. He requested they contact the surgical team, rather than admit Finlay under the paediatric team.

241. Whilst in the ED he was told by Dr Williams that the ED staff were already in the process of trying to arrange the surgical team to review Finlay.

242. At this time, Dr Tait knew that Finlay had a lactate of 7mmol/L which caused him concern in a child vomiting, and with stomach pain because he was of the view that this is usually

an indication that something is ischaemic and with bile stained vomiting and high lactate a bowel obstruction is a possible cause. Dr Tait stated that when he initially came to ED, Finlay was either in the radiology department having a CT scan, or one had been ordered and he was waiting to go there.

243. Ms Browne told Dr Tait that Finlay had been "quite unwell" and that he had been vomiting.

244. Dr Tait then left the ED and returned to his office. After the abdominal CT scan was performed, Dr Tait reviewed the images and saw that a volvulus was causing Finlay's presentation. Accepting that the timing of 8pm in his clinical notes could be incorrect, at some time after 8.53pm, Dr Tait then returned to the ED and spoke with Ms Browne further about Finlay's slightly high CO2 levels and the possibility that Finlay had sleep apnoea. At this time, Dr Tait recalled that Dr Williams and a male surgical registrar were positioned at Finlay's bedside; Dr Tait then left the ED to continue with his duties.

245. In evidence, to the best of his recollection, Dr Tait advised that he knew who Dr Ta was and confirmed that it was a male surgical registrar at Finlay's bedside, wearing light blue scrubs with a cap with a hairnet kind of appearance. Although he only saw the back of the person, he was "very confident that the surgical registrar was male". He did not know Dr Taina Lee at that time.

246. At around 10pm, the paediatric team was formally requested to consult regarding Finlay; Dr Tait spoke with Dr Nagar who had been contacted by NETS and was present in BBH, after being requested to attend the hospital by NETS:

247. In evidence, Dr Tait stated that at around 10pm:

> … I went back down once the CT scan had been completed, and it was clear that there was a - a - a - a volvulus bowel obstruction was diagnosed on CT scan, and then I went back down and spoke to the ED team again and then spoke to Finlay and his mother briefly. I would have maybe been there for a few minutes at most. And then went back - I was under the impression the surgical registrar had been called and there was delays in the surgical registrar being able to attend, and then I went back to the ward and just were - was monitoring - was obviously had other competing priorities up on the ward, and then delivery suite and things, and so I continued on with my role, and then I received a call later in the evening to come down because Finlay had deteriorated, and they needed extra assistance with IV access and stabilising from there on.

248. Dr Tait then attended the ED, where Finlay was in resus Bed 2 he was agitated and thrashing around. Dr Tait stated: "I knew that a diagnosis had been made and that there was a plan for Finlay to undergo surgery. This could not occur until Finlay was stable". Finlay was transferred to resus Bed 1 because his blood pressure fell and he continued to deteriorate. Dr Tait put a cannula into Finlay's arm, and the anaesthetic registrar attended to his airway. Once stabilised, Finlay was transferred to theatre. Dr Tait was not involved in discussions about transferring Finlay to another hospital.

Dr Irandi Jayatilleke (Surgical Consultant, BBH)

249. Dr Jayatilleke was the locum on-call general surgeon at BBH. Dr Jayatilleke's statement set out her involvement in Finlay's care just after 9pm on 30 September 2016. Prior to that point, she had been at home but was called to the ED to assess the MVA patient. She arrived at ED around 8.30pm; at this time, she assessed the MVA patient who had an active in-abdominal-bleed and around 9pm, Dr Jayatilleke was preparing and scrubbing for surgery and the MVA patient was being intubated.

250. Shortly after 9pm, Dr Jayatilleke recalled Dr Lee answering a call and Dr Lee told her it concerned a CT scan result that the ED wanted them to look at it regarding an unwell 16 year child; the ED had just received the result, hence the call to the surgical team. Dr Jayatilleke pulled up and looked at the films on the theatre computer. This was the first communication with Dr Jayatilleke about Finlay– she was unaware of his presence in the hospital until then. She could immediately see that Finlay had a caecal malrotation and a volvulus and needed surgery.

251. As the critical surgery for the MVA patient with intra-abdominal bleeding was about to commence – Dr Jayatilleke sent Dr Lee to assess Finlay in the ED whilst she started the MVA patient's operation. Dr Lee reported that Finlay's vital signs were stable, although he was in pain and had a distended abdomen consistent with the malrotation/volvulus.

252. Dr Jayatilleke understood that she needed to sequence the cases, given both required urgent surgery. She realised there was a chance – as Finlay was "haemodynamically adequate at the time" and because she had to operate on the bleeding MVA patient, that Finlay could be transferred to CHW in the time to complete the first surgery on the MVA patient.

253. Dr Jayatilleke recalled that she immediately rang the paediatric surgical team at the CHW and explained the situation and spoke with Dr Amanda Kusel. They agreed it made sense to transfer Finlay as he needed urgent surgery and because the other surgery was underway subject to how quickly transfer could be arranged, with the view of trying to speed up Finlay's care process. Dr Jayatilleke asked for a retrieval team to be organised immediately and she spoke with the NETS team and "felt assured they would retrieve Finlay as a top priority.

254. Dr Jayatilleke then proceeded with the operation for the MVA patient while also taking a number of calls about Finlay. A call was received that Finlay's blood pressure had deteriorated and so Dr Jayatilleke stabilised the MVA patient and un-scrubbed to leave Dr Lee to complete the next steps. This occurred around 11.05pm and Dr Jayatilleke described being surprised and disappointed to find that Finlay was still in ED. Dr Jayatilleke asked for the patient's transfer to theatre. She also spoke with Dr Catherine Langusch, the on-call general surgeon at the CHW and requested that she be available to provide any paediatric surgical advice intraoperatively.

255. Between 12.15am and 12.20am, Dr Jayatilleke commenced the procedure on Finlay after he was intubated and the initial anaesthetic process was complete. She performed an exploratory laparotomy and devolved malrotation.

256. Dr Langusch detailed the clinical support and advice she provided prior to, and during the operation. Dr Jayatilleke was determined to save as much of Finlay's bowel as possible, and discussed the plan and her findings with Dr Langusch.

257. At some point, the NETS team arrived and there was a direct handover. Dr Jayatilleke left the theatre after the procedure and while NETS were preparing the transfer she spent time with Ms Browne explaining the findings and that Finlay would go to the CHW.

258. Dr Jayatilleke stayed in contact with Dr Gordon Thomas, paediatric surgeon at the CHW who had taken over Finlay's care. In January 2017 she made contact to follow up on Finlay, hoping to hear of Finlay's progression – she was stunned and devastated to hear of Finlay's passing.

Mr Bradley Molenkamp (Director of Nursing and Midwifery, BBH)

259. Mr Molenkamp was the executive on call after hours and the acting General Manager (**GM**) on the night of 30 September 2016. He was the point of escalation of issues concerning staffing and resources. In this role, Mr Molenkamp was also responsible for communications and emergency and contingency management, including significant clinical incidents or issues.

260. Mr Molenkamp had no independent recollection of being the acting GM on the night, he accepted this, as was clear from the evidence that he was in that position on that night. Sometime after 9.30pm on 30 September 2016, Mr Molenkamp received a telephone call from CNM Lynette Sloane. CNM Sloane advised him:

> … that a 16 year old patient, Finlay Browne, was unwell and needed either surgery at Bathurst (though the locum surgeon had indicated she wasn't comfortable with this) or that he needed transfer and had been accepted to Westmead Children's Hospital but NETS weren't willing to transfer him because of his age.

261. It is important to note that the role of GM is critical in emergency cases such as this. Mr Molenkamp told CNM Sloane to instruct the SMO to call NETS in order to prioritise the transfer and if there was an absolute refusal to do so, then it may have been necessary to arrange for an adult retrieval team to get involved. Mr Molenkamp advised CNM Sloane to call him back if the situation was unable to be resolved.

262. In evidence, Mr Molenkamp said that in this conversation, he was triaging and providing advice over the telephone, as he typically did. He understood that time was of the essence for Finlay. No notes were made of this call.

263. Mr Molenkamp's statement evidenced no formal arrangements for a second on-call surgical team. In evidence, he stated that it was not an infrequent circumstance to require two operating theatres after hours based on his prior experience as an operating theatre nurse. However, he was not personally contacted to facilitate such a scenario. If the need arose, there was a consultation between the campus nurse manager, the nurse that was in charge of the operating theatres and a member of the surgical team, to coordinate that. Mr Molenkamp advised that he did not have the contact numbers of the appropriate people to call from his home.

264. Mr Molenkamp was given the opportunity to comment on criticisms made by A/Professor Luke Lawton to the effect that the response of the hospital executive was profoundly lacking. Mr Molenkamp did not accept this position, stating that he took the phone call from the CNM, who was a non-clinical person and in line with his usual practice, provided advice as to potential solutions to try and resolve the issue at hand.

265. However, in hindsight, Mr Molenkamp identified a number of things that he would have done differently, including requesting that the CNM call him back and confirm that the issues with Finlay had been resolved, or requesting to speak with the senior medical staff member in the ED and asking the CNM if she needed assistance and offering to come into BBH and provide an additional non-clinical resource.

Expert evidence

Associate Professor Luke Lawton (Emergency Physician)

266. A/Professor Lawton is a qualified emergency physician having practised since 2012 and at the time of preparing his report for this inquest, he was employed as the Clinical Director of the ED at the Townsville University Hospital. Professor Lawton also works as an aeromedical coordinator for the Northern Zone of Retrieval Services Queensland. He is appointed as an A/Professor at the James Cook University College of Medicine and Dentistry.

267. A/Professor Lawton was retained to prepare a report regarding the assessment and treatment of Finlay at BBH on 30 September 2016, and also the coordination of his retrieval to the CHW. A/Professor Lawton reviewed the documentation for the purposes of his report and relied upon the contemporaneous medical records as the primary source of documentation.

268. A/Professor Lawton noted the complexity of the chronology of events, and took this into account, however he noted that the key factor in determining Finlay's outcome was the delay in recognition of his volvulus.

269. In his opinion the principal reason this occurred was a lack of qualified emergency physicians present to supervise the Bathurst Base Hospital Emergency Department, which meant a failure to recognise a sick patient, and failure to lead and enact appropriate care in a timely fashion. He noted the failure to recognise a deteriorating patient and involve senior staff in care at an early point. The failure to communicate the

urgency of the patient's situation to the surgical and retrieval teams lost valuable and critical time. He further noted that there was also a failure of hospital management to recognise that the presence of two patients with an urgent operative requirement represented a major incident, and to enact all and any measures to resolve or mitigate the incident.

270. Specifically, A/Professor Lawton states that the key factor in determining Finlay's outcome was the delay in recognition of his volvulus, which should have been recognised at the latest around 7pm, which would have allowed simultaneous referral of the MVA patient and Finlay to the BBH surgical team, and for a decision to be made about an operative strategy. He notes that:

> a. Given the history and CT findings of the MVA patient, a reasonable emergency physician and surgeon would conclude she was bleeding into her abdominal cavity and needed an urgent operation;
>
> b. At 7.30pm when this assessment was made, the surgical team were not aware of Finlay, and so remained unaware of his competing surgical need or the need to potentially postpone the MVA patient's operation;
>
> c. When Finlay was referred, the surgical team were by then in an "impossible position" of trying to simultaneously operate and formulate a plan for Finlay, and had to choose between retaining him at BBH and awaiting the availability of the operating theatre; or transferring him to Sydney for urgent surgery;
>
> d. There continued to be the "unfounded assumption" of Finlay's stability;
>
> e. Retaining Finlay and awaiting theatre would cause delay, as would transfer of him – either course was likely to delay his surgery by a period of hours;
>
> f. A key issue for the clinicians was to determine which course of action would restore Finlay's bowel perfusion more urgently;

271. Additionally, A/Professor Lawton stated:

> The nature of the discussion that ensued while the surgeons were busy with a trauma laparotomy was disorganised and poorly co-ordinated. I consider that it might have been very different had both the Patient and the MVA Patient been presented simultaneously to the consultant surgeon at or around 1900hrs, allowing the surgical consultant to simultaneously triage and plan for both cases on their merits.

272. A/Professor Lawton opined that these issues arose because of a lack of qualified emergency physicians to supervise the ED at BBH.

Contributory factors

273. A/Professor Lawton also identified key contributory failures to the sequence of events, including the failure to recognise a sick patient, and the failure to lead and enact appropriate care in a timely fashion. It should have been possible to appropriately investigate and refer Finlay to the hospital's surgical team at or around 7pm. In addition there was under-resuscitation, delay to antibiotic administration and prioritisation of the wrong clinical issues in Finlay's acute management – such that his acid base status, vital signs and renal function were all worsening by the time of transfer to theatre.

274. There was a failure to recognise a deteriorating patient and involve senior staff in their care. There was a lack of leadership in the ED at BBH in terms of managing Finlay's clinical priorities. Involvement of the paediatric and anaesthetic teams managing Finlay's resuscitation was noted to be ad hoc and chaotic and should have been led by an Emergency Physician. There was a failure to take timely and regular observations of vital signs and a subsequent failure to communicate the true degree of illness severity to the surgical and anaesthetic teams.

275. He noted the failure of hospital management to recognise that the presence of two patients with an urgent operative requirement represented a major incident, and to ensure measures were taken immediately to resolve or mitigate the incident, and provide the necessary oversight.

Secondary issues

276. A/Professor Lawton also identified the following secondary issues relating to Finlay's care:

> a. *First,* the nature and scope of the initial referral to NETS, with prioritization of the wrong issues, and a failure to clarify a realistic retrieval timeframe given the decision that needed to be made about operating on site versus transfer for surgery.
>
> b. *Secondly,* lack of initiation of the sepsis pathway: it was not known that the issue was ischaemia rather than sepsis at the time of the patient's lactate result of 7.0. Had it turned out to be sepsis, a failure to initiate the sepsis pathway would have materially increased the risk of the patient dying; there was no reason to withhold anti-biotics and

use of the sepsis pathway would also have mandated the involvement of a senior doctor and regular observations of vital signs.

277. A/Professor Lawton stated that irrespective of the number of doctors ultimately working, the absence of a qualified emergency physician who is a Fellow of the Australasian College for Emergency Medicine represented a critical deficiency.

278. Ultimately, A/Professor Lawton considered the staffing standards at BBH as "grossly inadequate in terms of number, distribution and specialist qualification" to meet demand. A system of this nature risked a critically ill patient not receiving appropriately early or sustained senior doctor attention for investigation or treatment, as occurred in this case.

279. In A/Professor Lawton's view, this systemic failure "almost entirely determined subsequent events".

280. A/Professor Lawton was critical of the placement of Finlay behind the triage area without clear nursing supervision, when his presentation warranted placement in a bed in a formal treatment space. He considered that the presentation to a competent emergency physician with the triad of abdominal pain, abdominal distension and faeculent vomiting would have placed bowel obstruction as the head differential diagnosis or the likely diagnosis. The erroneous diagnosis of gastroenteritis was not indicated because it does not cause faeculent vomiting nor abdominal distension; nor is it typically associated with elevation of lactate. This would likely have been identified in a consultant led emergency department.

281. He further noted that the decision-making of junior doctors should always be monitored and overseen by a senior doctor who is an emergency qualified medicine physician, and further that a junior doctor would not be expected to be able to easily manage a paediatric patient with a complex condition who was also critically unwell. He noted that there should have been early senior management of the patient; in particular, following the abnormal lactate result of 7.0mmol/L which he observed to be a grossly abnormal result and a critical finding indicating a severe metabolic acidosis, which should have been a signal to a competent practitioner of a critical degree of illness.

282. Accordingly, the presence of a lactate of 7.0mmol/L should have prompted the most senior doctor in the emergency department to immediately recognise that the patient

was critically unwell, and actively involve themselves in his care. This would have included assuming clinical responsibility for directing the patient's investigation, treatment, and referral as a matter of urgency.

283. Dr Ta, the most senior physician on duty, was not a qualified emergency physician, however was inarguably the leader of Finlay's care and referral and when the lactate was returned, Finlay's CT scan should have been expected as a matter of urgency.

284. A CT could otherwise have been performed and provisionally interpreted by 7pm as a qualified emergency physician would be able to recognise a bowel obstruction and contact the surgical team.

285. Even with the hour-long delay to initial review, Finlay should have been referred to the surgical team at around 7pm which would have enabled appropriate and contemporaneous triage.

286. Additionally A/Professor Lawton noted that the frequency of documented observations of the patient were longer than would reasonably be expected and importantly that if these had been taken appropriately, the patient's state of deterioration would likely have been recognised before the blood pressure at 10.12pm, of 70mmHg systolic. He noted the evidence of Dr Ta giving a "heads up" to Dr Lee, Dr Williams appears to have been left to contact the surgical team and NETS without the urgency of the situation being conveyed given the "complexity and urgency" of this case (including the decision as to whether or not to transfer),and he said that this should not have been left to a junior doctor.

287. No senior doctor was involved in coordinating Finlay's care, including liaising with NETS which required a "very high level medical" decision and a high level of understanding of the degree of illness, the likely outcome of each course and the feasibility of retrieval. There was no clear team leader when Finlay deteriorated, and other clinicians from paediatrics and anaesthetics were called to assist, whereas an emergency physician would likely have appreciated the need for intubation and attended to same.

288. He noted that there was no blood pressure performed for almost two hours prior to surgical or NETS consultation and that an assumption of stability was conveyed to the surgical team by the intern based on a blood pressure taken nearly two hours previously. This had the result of influencing decision making and specifically, Dr Lee having been

told the patient was "haemodynamically stable" was not reasonable, given the absence of recent vital sign observations.

289. Mr Molenkamp was told of the circumstances including the patient's condition and the issues with the provision of surgery at Bathurst, as well as the need to transfer the patient and issues with acceptance from NETS and surprisingly, no further contact was made with Mr Molenkamp; nor did he follow-up the hospital seeking an update. Furthermore there was no designated medical member of the executive for Mr Molenkamp to engage with. He considered that this is not acceptable as this position provides clinical governance for the entire hospital medical staff and cannot be at any time empty nor inactive.

290. He noted that there was no senior executive doctor available to provide advice and problem solve the issue, despite being requested by NETS, and given it was clear that such support was needed by the clinicians at BBH.

291. The circumstance at BBH was in his opinion a "Major Incident" , being an incident where the location, number, severity of type of live casualties requires extraordinary resources and yet the only escalation pathway to a nursing executive member (Mr Molenkamp) was "convoluted", with poor access for the clinicians at BBH and NETS to directly converse. The CNM possess the requisite skills or knowledge to meaningfully contribute to high level medical discussions regarding the best place and means for an urgent operation. A/Professor Lawton was of the view that Mr Molenkamp did not appreciate the complexities of the situation. He should have made a "proper assessment" of the situation and clarified the issue, particularly as to issue of surgery versus transfer. He, or his delegate, should have contacted other local surgeons or a nearby hospital to assess potential mobilizable surgical resources to inform the decision to transfer or operate locally. A/Professor Lawton advised:

> In situations like this, in my opinion there needs to be a direct mechanism for senior clinicians involved in a crisis to directly contact the relevant executive, to ensure that relevant information is not inadvertently filtered or mis-stated through an intermediary who may not be qualified to assess or convey medical complexity.

292. Ultimately, there was no meaningful executive led response to the situation. The effective re-referring of the patient back to clinicians at BBH was "unreasonable and unhelpful":

> I would observe for the Court that should BBH have another future situation where there are two competing surgical emergencies, this level of executive response would in my opinion be likely to contribute to another adverse outcome for a Patient.

Lack of initiation of the sepsis pathway

293. A/Professor Lawton identified the lack of initiation of the sepsis pathway as warranting comment, although certainly not causative of Finlay's outcome. In this regard, after Finlay's lactate was returned as 7.0mmol/L, the risk benefit analysis for the patient was clearly in favour of initiation of the sepsis pathway, including senior review and antibiotic administration for which there would have been very little downside. Abdominal sepsis was only realistically excluded after Finlay's CT scan. The mortality for shocked patients with sepsis climbs steeply for every hour that antibiotics are delayed.

Summary of deficiencies in care

294. Counsel Assisting provided the following summary:

> In summary, A/Professor Lawton identifies the following principal critical faults in the care provided to Finlay at BBH ED:
>
> a. *First*, the placement of Finlay into a bed with no clearly defined nursing care, and no vital signs documented for 90 minutes after triage;
>
> b. *Secondly*, a failure to recognise that the lactate of 7.0mmol/L was a critical result indicative of life-threatening underlying illness;
>
> c. *Thirdly*, a failure to reconcile Finlay's symptoms of abdominal pain and distension and faeculent vomiting with a likely diagnosis of bowel obstruction;
>
> d. *Fourthly*, a failure to expedite a CT and act upon the results;
>
> e. *Fifthly*, a failure to provide senior leadership, oversight and management of Finlay's care, instead leaving the decision making and referrals to an intern;
>
> f. *Sixthly*, a failure to take a blood pressure for almost three hours between 7.15pm and 10.12pm.
>
> g. *Seventhly*, a subsequent failure to recognise, and then communicate Finlay's deteriorating state to the surgical team and NETS to best inform their decision making;
>
> h. *Eighthly*, an ongoing failure to correctly prioritise and manage Finlay's resuscitation.

295. In terms of the adequacy of the decision-making and coordination of Finlay's surgery at BBH, A/Professor Lawton considered that this issue stemmed from the late referral (being a formal consultation request) of the patient to the BBH surgical team; unsubstantiated communication that the patient was stable, factors which led to a failure to identify his immediate need for an operation. If Finlay had been referred to the surgical team at or shortly after 7pm, the surgical team would have a chance to "appropriately triage" – instead, they were placed in the impossible position of having to undertake a trauma laparotomy and coordinate the Patient's care. No meaningful assistance was received from the hospital executive on call.

296. However, when Finlay deteriorated and needed to go theatre, he was apparently transferred there as soon as feasible with existing resources.

297. A/Professor Lawton also considered that Finlay's transfer was impaired by the lack of a senior responsible doctor from BBH liaising with NETS. As to the adequacy of the care and treatment provided by the retrieval services upon arrival at BBH, A/Professor Lawton stated that "there was little additional that could be done while the Patient was in their care, except to provide critical care support and expedite his transfer, which they did". In relation to potentially preventing the fatal outcome, A/Professor Lawton concluded that the critical factor that compromised Finlay's care was the "timeliness of his work up and referral from BBH ED", which related to the skill set present at the time, and the lack of an appropriately qualified emergency physician. Had a qualified emergency physician performed the assessments that actually took place at 6pm, including being aware of Finlay's lactate, the degree of illness would have been recognised and Finlay would have been "expediently investigated and referred" to the surgical team. A/Professor Lawton recommended that a surgical opinion be sought as to Finlay's ultimate prognosis.

298. A/Professor Lawton gave opinions about the actions of Dr Ta that were the subject of cross examination. He agreed that hearing the additional evidence that Dr Ta did appear to understand the nature of the lactate finding, and that he did act to obtain a CT. A/Professor Lawton indicated that with the new information that he had now understood that the delay represents a number of the system failures. He accepted that Dr Ta did take some steps to formulate some planning for Finlay.

299. Overall from the expert evidence. It is apparent there were a number of clear failures, and A/Professor Lawton clearly identified each. I accept his account of what should and could have been done differently and far better.

300. Importantly he identified for the inquest the areas of error. I accept there was importantly a critical failure in leadership and there was no ownership of Finlay's presentation. There was no criticism by him of the JMO and equally it was his view that if accepting the surgical team only became aware when already in another surgery, there was limited opportunity for them to properly intervene.

301. It seems that from the time Finlay arrived at the hospital matters moved slowly. Certainly by 7 pm matters should have been expedited.

Dr Alan Meagher (Colorectal Surgeon)

302. Dr Alan Meagher, an experienced staff specialist colorectal surgeon at the St Vincent's Clinic, who became a Fellow of the Royal Australian College of Surgeons in 1990 gave evidence as an independent expert.

303. Dr Meagher considered the presentation of the MVA patient and was of the view that there were good reasons to proceed reasonably quickly to the operating theatre with that patient.

304. Dr Meagher states that the surgical registrar and surgeon "arranged appropriate further scans and expeditiously arranged for transfer to the operating theatre and appropriate treatment - a midline laparotomy with oversewing of the perforated bowel and a washout of the abdomen".

Which patient should have been prioritised for surgery?

305. Dr Meagher notes that Dr Jayatilleke and Dr Lee state they were only told about Finlay's situation around 9pm just as the MVA patient was being anaesthetised, and that at the time they were told that Finlay was hemodynamically stable. He was of the opinion that the surgeon's conduct was reasonable in those circumstances.

306. Dr Meagher said that it was a complicated situation. If Dr Lee had been told about Finlay's high lactate and in turn that had been communicated to Dr Jayatilleke that would have been a different scenario. He considered if Finlay's scan had been available the competing question of whom should have been operated on first would have been

difficult. There would have been strong support to discussing Finlay's case with a paediatric surgeon and going ahead first with him, other though the MVA patient would then have been placed at a substantially increased risk of morbidity and mortality. Ultimately, Dr Meagher opines that assuming Dr Lee and Dr Jayatilleke were first formally asked to see Finlay at around 9pm when the MVA patient was starting to undergo anaesthesia, given the information available at the time – including Finlay's physical condition and the condition of the elderly MVA patient – "that the decision making and co-ordination and timeliness of Finlay's surgery at Bathurst Base Hospital was reasonable".

307. As to the adequacy of the care and treatment provided by the surgical team at BBH, Dr Meagher notes that Dr Jayatilleke's immediate consideration of seeing whether it was possible to arrange a relatively rapid transfer of Finlay to a specialised unit whilst she was operating on an elderly patient who was bleeding and had a bowel perforation from an MVA was reasonable.

308. Importantly he noted that a complete midgut volvulus as occurred in Finlay is a rare occurrence and as a practising colorectal surgeon for over 35 years, Dr Meagher had never seen a patient with an acute full midgut malrotation as occurred in Finlay, that is, he had never seen such a severe case, which presented as acutely as Finlay's did. He noted that midgut volvulus tends to occur at a much younger age, and is relatively rare in adults. Although Dr Langusch appreciated that such patients could become haemodynamically unstable very quickly because such a long length of bowel could become ischaemic quickly, it was reasonable that Dr Jayatilleke as a newer consultant surgeon may not have been aware of this.

309. He noted that Dr Jayatilleke and Dr Lee took phone calls, and tried to do their best to look after both patients, modifying the management plan appropriately as Finlay's condition changed while listening to advice of more experienced specialists, in particular Dr Langusch. Dr Jayatilleke also initially spoke with someone at the CHW (known to be on-call paediatric surgical registrar, Dr Amanda Kusel), and from the discussion, a transfer sounded like it would be reasonable. Once the operation was commenced on Finlay at Bathurst, immediate transfer to Sydney was also appropriately arranged by the surgical team.

310. In the great majority of patients with a volvulus involving the bowel, time is not nearly as critical as it was in this case of a complete midgut volvulus. In the great majority of patients with simple bowel obstructions, even if there is an area of volvulus, Dr Meagher noted that there are often delays of many hours in reaching the operating theatre.

311. Dr Meagher assessed Finlay's prognosis. Having been taken to theatre at 11.30pm he indicated that the degree of marked ischaemia of such a long length of bowel is associated with a very high risk of mortality, or otherwise long term morbidity. This is a result of the development of short gut syndrome and often a need for TPN [Total Parental Nutrition]. Given the situation as it was at 11.30pm, he noted "Finlay's prognosis was very poor in that situation and his chance of long-term survival was low".

312. Being taken to theatre around 6.30pm to 7.30pm Dr Meagher said that it would be "relatively rare" for a patient who presented as Finlay did (that is with a history of vomiting, abdominal pain and distension) to have undergone blood tests, a CT scan, surgical assessment and then be taken to the operating theatre [within 2-3 hours of arrival]. However, Finlay's lactate was found to be high (7.0mmol/L) at 6pm, and Dr Meagher stated: "I do recognise the importance of that". He also noted that the significance of the bleeding in a bowel movement. Dr Meagher stated that if the bleeding did occur shortly after the onset of pain at around midday, it's "more likely than not that there was some degree of ischaemia of the bowel at that stage".

313. He noted that there are no reliable studies as to how long ischaemia due to a mid-gut volvulus might take to develop, in part given the rarity of such cases of extensive acute mid gut volvulus. Additionally, "the development of venous mesenteric ischemia is not a simple linear process in terms of the time since onset of the 'twist'"; given Finlay's past history, it is possible that he had a chronic twist (partial volvulus); the latest episode may not have been much different to past episodes but a major superior mesenteric vein may have been thrombosed, "leading to the unusually rapid progression of oedema and ischaemic changes". Although the bowel was "very ischaemic" and remained borderline throughout Finlay's stay at the CHW, the peristalsis that occurred when the bowel was untwisted raised the "possibility" that it might fully recover.

314. Dr Meagher provided the following opinion:

> I hope it's clear that I have given this a lot of thought. Given the likely approximate onset of the critical extra twist in the bowel and/or thrombosis that probably occurred at around midday that day, and given the fact that whilst a limited area of bowel was grossly ischaemic and indeed perforated, and recognizing that the remainder of the bowel was borderline when Finlay was taken to theatre at 23:30 hours, I think all I can really say is the following. In directly answering your question, if the devolving surgery did commence (given ideal conditions) at or around between 18:30 and 19:30 there would have been a reasonable possibility that a substantial length of the small bowel would have been in better condition. I really can't say more than that scientifically. Conditions probably would have been somewhat better but I just honestly don't know how much better. Finlay probably would have had a somewhat better chance of surviving but it's very likely he still would have had a particularly prolonged course in hospital with multiple operations, and it's certainly entirely possible that the outcome would have been no different. I do note that Dr. Thomas at the conclusion of his statement says something similar to this. The fact is despite all the intense surgical and medical efforts at Westmead Hospital, Finlay's bowel was markedly affected by the ischaemia. This ischaemic effect probably would have been less if he had been taken to theatre earlier - it's likely, for example, that there would have been less venous thrombosis, at least to some extent. It is conceivable that this difference would have been enough to allow Finlay's bowel to heal better and it may have been - for example - that he would have recovered after the initial discharge from Intensive Care at Westmead but there was still a strong possibility that he would have required prolonged home TPN and prolonged bowel rehabilitation. I've thought a lot about whether I could perhaps place percentage figures in here, but I think that would just honestly be very speculative.

315. Dr Meagher's oral evidence was to similar effect, and was ultimately limited by the poor state of the clinical notes.

Could the fatal outcome have been prevented?

316. When asked what may have prevented the ultimately fatal outcome for Finlay he said:

> This is a very broad question. Firstly, I should state that it's particularly likely that some of Finlay's previous episodes of marked abdominal pain described by his Mum Rachel may well have been due to chronic symptoms related to incomplete volvulus or a volvulus that untwists by itself. We only know that in retrospect. As explained above, I have seen patients with malrotation of the bowel and it's not rare for them to present as adults with intermittent episodes of abdominal pain but it often is only diagnosed if they undergo a CT scan.
> …
> If however at some stage Finlay did have a CT scan of the abdomen then it's likely that the malrotation would have been diagnosed and a

> prophylactic Ladd procedure could have been performed but this is all clearly theoretic. Many patients who reach Finlay's age with a malrotation do not suffer symptoms and will never suffer a complete volvulus and do not require such surgery.
>
> I should state somewhere here - looking from the point of view of Finlay's family - that I see many young patients with recurrent episodes of crampy abdominal pain and bloating and it is relatively uncommon to put young patients through a CT scan of the abdomen to investigate these episodes. Even when such CT scans are performed it is rare for there to be a diagnosis of malrotation causing these symptoms. Indeed the great majority of families who have a child with these sort of symptoms do not strongly request further investigations. The fact is that Finlay suffered a very rare condition, which could not be foreseen by Finlay's family.
>
> I have outlined above that it is possible if under ideal circumstances he had undergone surgery earlier that day then a fatal outcome may have been avoided but, again, his quality of life may well have been severely affected.

317. When questioned in evidence as to whether if Finlay been operated on earlier – that is, between 6.30pm and 7pm – Dr Meagher was unable to say if he would have survived or not. However, Finlay's chances of survival would have been increased if he had undergone an operation several hours earlier.

Treatment at the Children's Hospital Westmead

318. As to the surgery performed at the CHW on 1 October 2016, Dr Meagher opined, having reviewed the voluminous operation reports and much of the peri-operative care, Dr Meagher stated his "strong opinion" that the later surgeries and treatment performed at the CHW were "entirely reasonable", and agreed that everything was done that could have been done to assist Finlay.

ANALYSIS OF EVIDENCE

319. WNSWLHD accepted on the first day of the inquest that the care and treatment provided to Finlay in the Emergency Department was not adequate care. The unchallenged evidence of A/Professor Lawton set out those deficiencies which I accept. As outlined above, the findings and as clearly enunciated by the A/Professor these failures resulted in a lack of appropriate identification of the cause of Finlay's illness and treatment of the same.

320. There was considerable factual contest between Dr Ta and Dr Lee. The evidence was further affected by the lack of contemporaneous notes. There were no notes from Dr Ta available, and no notes from Dr Lee as to her review of Finlay. There was no doubt that each witness was attempting to give an accurate account of their recollection, and tried truthfully to recount events as they now recall. However, in relation to both witnesses I have concerns about both memory accuracy and reliability. The passage of time that passed means that I cannot be satisfied that Dr Lee was given any "heads up" on Finlay and his lactate result. The fact is however, that on nobody's account was a formal referral made at that time from ED to surgery. On Dr Ta's best recollection he was told, even after receiving the CT scans which he could interpret, that he needed to wait for the report to be generated. In reality there was nothing preventing Dr Ta from requesting a formal referral to surgery if he had seen the need to do so.

321. There is the evidence of Dr Ta with his head is hands, lamenting inaction in front of Ms Browne which I accept. This corroborates that he was experiencing frustration and identified inaction. Dr Lee did access Finlay's records at a time when potentially the lactate level was available.

322. I accept from the evidence that Dr Ta did have some discussion with Dr Lee, but I cannot be satisfied with the content of that conversation, and therefore not satisfied of the level of knowledge that Dr Lee had about Finlay's presentation. It was also apparent that Dr Lee did review Finlay's records at an earlier point. It may have been that Dr Ta did communicate some important matters to Dr Lee, but communication was an issue, and the message was not adequately relayed in a manner that prompted the immediate action that was required.

323. It is submitted both by Counsel Assisting and Counsel for Dr Ta that I do not need to resolve this factual issue, and I accept that. What I can find is the communication lines were unsatisfactory between Dr Ta and Dr Lee. It also highlights the benefit of thorough and contemporaneous note taking.

324. In any event it was clear that no one turned their mind to the fact that there was but one surgical team and very potentially two surgeries.

325. The failings were identified as follows:

    1. A delayed diagnosis of Finlay;

2. A failure to recognise a critically ill patient and enact appropriate care in a timely fashion;
3. failure to identify a deteriorating patient and involve senior staff;
4. Failure to communicate with the surgical team;
5. A failure to enlist early intervention of the retrieval team;
6. Failure to expedite a CT scan;
7. Failure to provide senior leadership oversight and management of Finlay; and
8. Failure to take appropriate observations, such as blood pressure which was not taken for almost three hours.

IMPLICATIONS

326. Dr Meagher noted the rarity of Finlay's presentation, and noted that even if surgery had taken place in an ideal timeframe, although a fatal outcome may have been avoided, although he noted the significant risk that still existed, his quality of life may have been significantly impacted.

327. However, if the surgery had occurred earlier there was a reasonable possibility that a length of small bowel would have been in better condition. It was difficult for Dr Meagher to determine the likely outcome in better conditions, but it was likely he would have had a somewhat better chance of survival and probably a prolonged course of hospital with multiple operations. It was also the evidence that Dr Meagher said that the outcome may have been ultimately the same.

328. This was the evidence. However, it was the case that Finlay deserved a chance, and the reality here is that the treatment he received was below appropriate standards. Proper care would have afforded him a chance, and of this he was deprived.

EXECUTIVE RESPONSE

329. The evidence was that there was no meaningful, constructive hospital driven response to the crisis as it was unfolding. It appeared there was insufficient leadership available to manage the situation by hospital administration. The expert evidence supports a finding that there were no formal processes or procedure to follow in a case that required a second operating theatre to be opened if needed. There was no medical executive on duty. There was no follow up by Mr Molenkamp the most senior hospital executive on duty regarding Finlay.

330. There was a lack of understanding within BBH at that time of the importance of that role. There was no effort made on behalf of the executive to manage what could only be described as a medical crisis. It appears clear on the evidence that the executive role at the point Mr Molenkamp was contacted is critically important, it is an opportunity to oversee a process administratively, to access resources and focus on solutions relating to the medical response that can be ultimately provided, allowing as much immediate medical attention as possible to remain the continued urgent focus of the treating team.

331. A/Professor Lawton raised that this type of response would likely contribute to further adverse outcomes in the future unless corrected. The evidence of WNSWLHD was that some steps have been taken to address the issue of governance and escalating critical incidents, and the evidence on that front was an impressive change. It was clear that the person now in the role is taking steps to form good relationships within the region, and ensure that it is clear who is on duty and when, and importantly what is expected.

332. The inquest was able to identify areas that remain necessary to resolve in this area.

Issue of Unconscious bias and whether that impacted Finlay's care

333. The evidence on this point was compelling, and raised the issue of attitudes or stereotypes that unconsciously affected perceptions, then affecting reactions, interactions and decision making.

334. It is a very important issue and one best expressed by a mother watching her son navigate systems for some 16 years. Ms Browne had learned to be alive to these challenges, and made very interesting comparisons between the experience of Finlay compared to the treatment and experiences that she had witnessed with his siblings who did not have a disability. She explained that it was always such a different experience. Ms Browne steeled herself for their attendance at the hospital with Finlay expecting it to be more difficult and complex. This was not consciously done by any staff member, however the value of reflecting on what might be unconscious bias allows focus to be placed on its very existence, allowing it to then be addressed.

335. The matters identified by Ms Browne was the perception that she and Finlay were an inconvenience even before assessment. Finlay was placed in a location out of sight, into a cubicle rather than an emergency bed. She found it extremely difficult to make eye contact with staff, who she felt averted gaze. There was an invisibility to Finlay, and a

speaking directly to Ms Browne rather than including 16 year old Finlay actively in the conversation and include him. She noticed a failure to take regular observations, or do basic clinical tasks such as keeping a record of output on a fluid chart, assumptions were made that he was nonverbal, and when she raised concerns using a verbal REACH call she was dismissed.

336. These things might be one by one explained away, but together, when being raised by an experience nurse and mother of three children they gain strength, and appear not coincidental with Finlay's presentation as a down syndrome boy. It is no hospital's desire for any patient to feel the way Ms Browne did that night: "I felt unseen, I felt like my child was less than…".

337. Cumulatively this is support for more attention to be directed towards unconscious bias, and her words were powerful as she advocated for "open and courageous communication going forward for this unfortunate turn of events to actually result in something positive".

NETS

338. Whilst this inquest has focused predominantly on the care and treatment Finlay received at BBH, it ought to be noted that, but for NETS and the retrieval team, Finlay would not have been able to receive the surgery and care that he required, at the CHW. Such care and skill provided Finlay with the chance to spend time with his family for a little while longer. The surgery Finlay required was complex and required special care, of which he, plainly, could not receive at BBH. It is for this reason, that NETS and its services to New South Wales was considered throughout the inquest, and the fundamental role it played in providing Finlay a chance of survival.

339. Some very positive evidence to come from this inquest came from a representative of NETS, Dr Kathryn Carmo, who is a neonatal intensivist at the CHW and also acting state director of NETS. She was actively involved in Finlay's case when she was contacted by the surgical registrar at 9.57 pm.

Nature and role of NETS

340. Dr Carmo explained that the role of a NETS consultant is to:

> … function as the glue in the system that helps a sick child get from a rural or regional or metropolitan hospital where that child is overwhelming the services or is beyond the capacity of that hospital to manage the patient. So, we take the initial call, often from very junior doctors and a consultant is managing that call instantly or as soon as you can join the call. We give advice, provide stabilisation and take intensive care to the child and then transport them safely 99% of the time.

341. NETS is an extraordinary unit, and it will be a relief to many to know of its existence. We had the benefit of a view out at the facility in Bankstown, which was not for the purpose of evidence, but rather to gain a better understanding of how the organisation works, and of its capability.

342. NETS operates in very modest accommodation, it is small and compact. Dr Carmo elaborated on the role of NETS in her evidence, and at its most basic it can be described as the child retrieval team. However the service it provides is much greater than its humble acronym. NETS is a lifeline with the possibility to be a major resource to both city, but very importantly, country hospitals. Dr Carmo explained that the hierarchy of medical practice is fairly rigid, with like speaking and to like. For example it is most likely that the most senior specialist will speak to a peer, rather than a junior doctor having that access directly. NETS is structured differently. It has specialists situated at its coalface. A senior experienced doctor like Dr Carmo will lead the call. That doctor will assess the situation, having access to a team of nurses. All parties have access to computer and camera screens, and can even go live into the operating room to gain a live visual of what is taking place.

343. The senior doctor and nursing staff will quickly identify the specialists from around NSW that they need to involve in the case as it unfolds, and they will go through a process of sourcing those specialists. They then are in a unique position to draw from the most senior ranks of NSW medical officers to assist and advise even the newest, most junior doctor at any hospital in NSW. They take the role of advising, and if necessary acting to retrieve a child. They are able to, where appropriate, be present remotely in an operation, resuscitation or other situation, and give guidance as to best steps taken while simultaneously arranging to collect a child to bring them back to receive specialist care.

344. They have access to both helicopters and planes, and they have teams on standby to immediately launch into action to undertake retrieval. They work hard on the development of equipment. Equipment is so important for children because often available equipment, tubes, medical supplies at general hospitals cannot be available at country locations for every medical event. NETS ensures they take all equipment with them to ensure the best survival opportunity for the child.

345. There was evidence given that once they had been situated in a building at Westmead with a helicopter pad with pilot ready to take off at short notice. They now share flight resources with adults, and it was the adult team that determined the priority of the helicopter.

346. Although they are based at Bankstown, the airport that they must attend for fixed wing flights is Sydney. These were changes explained in evidence that was of concern to the team, and would be of concern to those waiting for a NETS arrival.

347. These are not matters that were to impact any delay in collecting Finlay, although that night NETS was down one team, the weather prevented helicopter access and fixed wing transport was to be the only method of retrieval.

348. Dr Catherine Langusch was a paediatric surgeon and visiting medical officer at the CHW and was involved in NETS calls and provided assistance to Dr Jayatilleke during the operation at Bathurst on Finlay. Dr Kusel was the on call paediatric surgical registrar at the CHW, and Dr Una Ionmhain was the senior registrar in retrieval medicine working for Care flight and the NSW Ambulance Helicopter emergency medical service, and was the retrieval doctor who brought Finlay to the CHW on 1 October 2016.

349. RN Anita Zovic was the flight nurse working for AMRS, who also assisted in Finlay's retrieval. Their involvement was that sometime after 9 pm Dr Jayatilleke spoke with Dr Kusel about Finlay. Dr Kusel spoke to Dr Williams and spoke with Dr Langusch her own consultant about possible transfer to CHW and spoke about the most appropriate surgical management of Finley. It was agreed that Finlay required urgent surgery, being a laparotomy, devolving and Ladd's procedure. Both Dr Kusel and Dr Langusch were concerned about the times to get Finlay from Bathurst to CHW.

350. The first NETS conference call was initiated by Dr Kusel to discuss management of Finlay, and lasted for around 29 minutes. The second call was made at 10.51 pm and after

numerous calls with the AMRS as to the logistics of retrieval arrangements and the appropriate mode of transfer given the inclement weather, a retrieval aircraft left Sydney at around 13.00 am and arrived at 1.25, by 3.10 am the team had first contact with Finlay in the operating theatre, departing at 5.13 am and arriving around 5.40 am and by 6.55 am he arrived at CHW. Finlay was critically unwell with evidence of multi-organ dysfunction and failure secondary to caecal volvulus, bowel ischaemia and peritoneal soiling. He was unwell during the flight, however he was treated best as possible, and there is no issue with the adequacy of the involvement of his retrieval.

351. A/Professor Lawton noted that the initial focus of the consultation with NETS was not as focused as he would expect, and thought the only realistic option was to retrieve him after the devolving laparotomy. He considered that the initial focus should have been focus on a realistic transfer time, given transfer was urgent and inevitable. He was also concerned at the fact that a focus was on a bed availability, when in his view bed availability for a critically ill patient should only be a secondary focus, the first should be getting them off the ground and on the way. He questioned the length of the conversations had, however did not consider that these matters ultimately influenced the outcome.

352. A/Professor Lawson did not have the benefit of hearing the evidence of Dr Carmo. Dr Carmo did have the benefit of A/Professor Lawton's report. Her evidence was that when she came into the first call, which was played in the inquest, she already had significant prior knowledge. She knew there were only four NETS teams available that day, there are normally five. A baby had become urgently unwell that evening and the consultant undertaking the phone coordination went out themselves to rescue the baby. Dr Carmo stepped in to take the phone to cover the NETS. Helicopters were not flying that night, given bad weather. She knew transport and staffing was going to be a difficult task.

353. Dr Carmo has 20 years of experience with malrotation volvulus in children, and has conducted research in that area. She reflected that the first words she said on the call, an expression immediately reflecting the urgency of the situation. She said knew the precarious situation Finlay was in from the outset. She explained that the discussion about admission to CHW was because she was sorting out the referral. The referral was actually stemming from CHW and not Bathurst. She agreed that she spent some minutes unravelling that, but then moved swiftly to resolving Finlay's problem. It should

be noted that concurrently she was managing a critically unwell 6 year old, for whom she had no team available to assist.

354. Dr Carmo noted that the weather was as it was, and that there were difficulties given the team limitation.

> I only had four teams on the day so normally in a situation like that when I get called about a child, I would put a team in the air straight away. Even if they get there and the decision is surgery should happen in Bathurst, I would still have a team going to them because that child is obviously in a crisis and I could tell that Bathurst themselves where in crisis.
>
> I mean they were overwhelmed with the patients that they had to deal with on that night. So we would send help as soon as possible. I don't have five teams on that day and I know a coroner in about 2010 said NETS should have six teams a day. We do have a very supportive executive in the children's Hospital network who are helping us to staff NETS adequately and helped us to build the team. Unfortunately, the current budget we were hoping that we would get and enhancement, but that hasn't come through yet with the current health budget. We've been fairly under-funded for many years, since developing the network.

355. Dr Carmo explained that what she needed that night was the assistance of a FACEM and to have an executive on call. She explained usually dealing directly with executive management to work with them to resolve incidents such as this.

356. Dr Carmo also noted that a local paediatrician needs to be involved in the care of a child requiring advice or retrieval by NETS. She often works closely with a paediatrician to assist in galvanise a situation and recognise what is going on and lead.

357. There was also evidence of the NETS need to access to helicopters, and explained this is a point of contention, given of the three helicopters available, that there is one helicopter in Sydney that is allocated to children, in a situation where NETS require it at a ratio of two-thirds flying time for children compared to adult patients. She described the fact that often NETS takes intensive care to children, as opposed to adults, who may be capable of managing the first six hours of intensive care in a rural or less major hospital, however, the first six hours of intensive care for children often requires equipment to be taken to the child, and therefore access to helicopter is critical. She noted it would be a great improvement in New South Wales if they maintained priority

access to at least one helicopter at all times, together with a designated NETS fixed wing aircraft.

358. In late 2016, NETS relocated from the CHW at Westmead to the Bankstown Aerodrome. Dr Carmo explained:

> … at the end of 2016, we moved away from the Westmead campus where we had a helicopter on our roof. So, it used to take us 20 minutes to launch a helicopter for children and now it takes 50, which is a long time for children in – particularly in Finlay's case, where he had a twisted bowel and he wasn't getting blood flow to his bowel.

359. This change is difficult to understand, especially to provide specialised emergency care to rural children. It seems the change that occurred was that previously there was immediate access to a helicopter that was located with them. Now the process is that they may seek out a helicopter for use.

360. Dr Carmo also stated that this change has been a 'backwards move for all children in New South Wales to reallocate the helicopters centrally'.

361. Dr Carmo related a powerful example in evidence. She explained that previously they had a smaller helicopter, that was used to move around Sydney in, particularly useful in peak hour. She explained the new larger versions take longer to get off the ground, although faster in the air not as practical for Sydney based use. She explained :

> we had a child who fell off the back of a chair in … - a cafe and he had a brain injury. He had a bleed and we got a team there quite quickly. … So, we wouldn't be able to do that in 2023 because we wouldn't have access to the helicopters to fly around and do those things so quickly.

362. It appears that this was an example where changes have been made that have had a negative effect on the efficiency of NETS. These effects ultimately relate to delay, and delay is the enemy of those attempting to provide emergency treatment to children, particularly in remote locations.

363. As to any potential hesitation in doctors contacting NETS, Dr Carmo stated (emphasis added):

> So, we take feedback like that very seriously because <u>we don't want anyone to feel intimidated by calling NETS</u> … There shouldn't have been any impediment to calling us about a lactate of 7. I mean please tell me about that as soon as you know so that <u>we can get help coming but also help you in stabilising the patient and in galvanising the surgical</u>

> response if the surgical response is feeling a bit, you know, reticent because of their adult skills.

Age cut-off for NETS referral

364. The evidence indicated that babies, children and adolescents can be referred to NETS up until their 16th birthday. Finlay's age (noting he turned 16 years old on 30 September 2016) was thus an issue in terms of whether the CHW could accept him.

365. In evidence, Dr Carmo stated that in her opinion, this age cut-off is artificial – pointing out that children cannot vote or drink until they turn 18 years old. She also noted advised that some adult clinicians are uncomfortable managing children between the ages of 16 and 18 years. Notwithstanding, the Sydney Childrens Hospital Network (**SCHN**) have a "really hard cut-off – if they're unknown to the Children's Hospital, they usually won't admit them".

366. Although not speaking on behalf of NETS, as a child advocate, Dr Carmo gave evidence that she wished better delineation for children within the health system, and that they remain children to the age of 18, which is consistent with the majority of other practices within our state and indeed our country.

367. As to how a child with a disability may factor into the retrieval age limits, Dr Carmo stated very powerfully and clearly the following, and I note her overall demeanour and conduct throughout her evidence left no doubt that this is her practice, belief and expectation in practice:

> … I don't think it factors into retrieval at all. I think people who work in paediatric specialities highly value children with down syndrome, and we understand absolutely how valued they are in their families. And certainly, from my understanding of Finlay, was he was a very healthy young man who suddenly had this problem and, you know, that wouldn't have factored in - in any way in my decision-making in retrieval.

Supplementary statement of Dr Mary McCaskill

368. Following the view of the NETS facility and in response to certain specific questions posed by those assisting, a further statement was provided by Dr Mary McCaskill, Director Medical Services and Clinical Governance, SCHN, dated 4 March 2024.

369. Amongst other matters, that statement highlighted the significant increase in NETS' workload during the period 2016 to 2023, including in terms of the provision of advice and retrieval services.

370. As to service improvements to NETS, Dr McCaskill noted that SCHN and NETS are reviewing the use of technology within NETS, "with close linkage with clinical systems in hospitals across NSW, communication systems with NSW Ambulance and for clinical records from NETS to be accessible to external treating clinicians as well as the NETS team." She noted the NSW Health long-term strategy to move to a Single Digital Patient Record to provide clinicians access to individual medical records through a single system.

371. Of particular note, Dr McCaskill stated:

> Improving availability and timing for NETS to access helicopter and fixed wing vehicles is being considered by SCHN with NSW Health and NSW Ambulance in reviewing service arrangements.

372. Dr McCaskill's response to the following question warrants excerpting in full (emphasis added):

> *Subsequent to the oral evidence of NETS Deputy Director, Dr Kathryn Carmo* [who was a lay witness in this matter], *have there been cases where, following the removal of helicopters from SCHN, urgent retrieval of patients was required, however due to logistical issues (i.e. limited availability of aircraft or pilots) such retrieval was not able to occur? Please provide details of same and relevant statistics, to the extent possible.*
>
> 17. The complexity of each patient's condition, the limitations around flying related to weather and pilot timing and the use of other means of transport, mean it is not possible to identify specific cases in which retrieval was not able to occur because of logistical reasons alone.
>
> 18. The aim of NETS/ SCHN is to ensure best use of the available helicopter vehicles and for NETS to focus on patient care
>
> 19. Helicopters used by NETS have been managed by a third party for a number of years. <u>SCHN is working with NSW Health and the helicopter contractor to improve the timeliness of helicopter responses for NETS patients.</u>
>
> <u>20. NETS will now, through SCHN, be involved in determining the requirements of access to the helicopters for NETS patients.</u>

373. A/Professor Lawton's comments as to NETS communications were not intended as a criticism merely feedback. There was certainly no suggestion those matters impacted any way on the outcome for Finlay, other than in a positive way.

374. The call can be described in this way, Dr Carmo remains calm, in control and able to direct as she navigates the confusion and lack of leadership and chaos that was evident in Bathurst that night. It was apparent that she was initially getting her bearings, that she, although somewhat surprised at the lack of leadership, calmly stayed on the line and continued to work with them until a solution had been reached. At a point in the call she insists that as the junior doctor goes away that she is remaining, so he can return to report back to her. She does not abandon Finlay, she is fully committed to his care and finding a solution.

375. In evidence Dr Carmo reflected on her first words on the call, reflecting on the fact that with her vast experience she knew the danger Finlay was in. It was not easy to pick up those words at all as a listener, or the level of concern and dread that she herself held at the time given the circumstances that she was facing, because her manner at all times was professional, steady and in control. It was clear she brought common sense to a difficult situation. It was obvious that in a crisis this is the team you would wish to be present. In my view after hearing the call, Dr Carmo remaining on the line, communicating so effectively, taking control and having the discussions that she had was exactly what Bathurst needed. At one point a junior doctor indicates he has to leave the call because he is "getting a call from NETS". This is meant as no criticism of the doctor, but that was the level of confusion that Dr Carmo was facing. She was hindered in her ability to access senior doctors or administration. Nonetheless she persevered.

376. Dr Carmo is an extremely experienced doctor. Her evidence was impressive, her assistance to the Court was immensely informative and helpful. The recorded telephone calls in which she led discussion left only one question: Why were NETS not contacted earlier?

377. It was apparent that more could be done to raise the profile of NETS. So many junior doctors are sent to country locations and it seems obvious that one of the lifelines that all country emergency physicians should know is that of NETS. This was highlighted in the very difficult position Dr Williams was placed in that night, with no understanding of the processes.

378. Dr Carmo also gave evidence that NETS work very hard on being at all times approachable. The best outcome is one where they are not needed to intervene or retrieve, but instead can assist in local management.

379. There is clearly a big divide in services that can be provided throughout our vast NSW regions, and NETS deserves attention and support as a potential leveller, and one that parents in NSW would be glad to know is available.

HOSPITAL RESPONSE SINCE FINLAY'S CASE

Lessons Learned and Systemic Change Since October 2016

Issue

380. A focus of this inquest related to what relevant changes occurred since Finlay's death and was explored as follows:

> **3. What steps have been taken by BBH and the WNSWLHD, and NETS in relation to any lessons learned from Finlay's death, and whether those steps are adequate?**

Evidence

381. In the seven years since Finlay's death, the WNSWLHD has conducted various reviews and taken steps to address certain issues arising from them, and given the effort taken it is important to repeat and acknowledge them.

Case review on 20 October 2016

382. On 20 October 2016, a case review discussion was arranged by the then Locum Director of Medical Services BBH, Dr Elizabeth Barrett. It was relevantly attended by Professor Brendan Smith, Dr Mandira Chakraborty, Dr Daniel Tait and Dr Aman Williams. It concerned a review of the clinical records and discussion of Finlay's presentation on 30 September 2016.

383. Complicating factors were identified as:

    a. Finlay's Down Syndrome and Autism Spectrum Disorder;

    b. the outbreak of gastroenteritis at Finlay's school, which may have contributed to some diagnosis bias;

c. the multiple teams involved in Finlay's care – i.e. the ED doctors, paediatric and anaesthetic registrars and the surgical team;

d. that the ED was busy and Finlay was managed by an intern (although a more senior ED doctor [Dr Ta] was consulted);

e. that Finlay presented at 4.30pm amid some shift changes;

f. that an elderly female patient (the MVA patient) was also unwell in the ED with a perforated bowel, and required urgent surgical intervention; and

g. a fixed wing aircraft was necessary rather than a helicopter, given bad weather.

384. During that review, the following issues were identified:

a. the need for a designated senior ED doctor on all shifts to guide the management plan of patients, review triage categories, escalate care where necessary and alert /liaise with NETS where necessary;

b. the need to ensure that staff are aware of the significance of a raised lactate when there may otherwise be an unclear clinical picture;

c. the window of opportunity for early surgical review and subsequent transfer was lost during the initial delays in the ED;

d. the need for an Intensive Care Unit (ICU) registrar to assist in BBH with a management of critically unwell patients (where a lactate of 7mmol/L could be a trigger for ICU referral/involvement regardless of the cause);

e. the importance of timely documentation from all teams involved in Finlay's care;

f. consideration of having a second anaesthetist on call; and

g. inadequate nursing cover during periods of significantly increased ED activity.

Remedial changes or improvements

385. Subsequently, an initial statement from the former GM of BBH, Ms Cathy Marshall dated 6 May 2022, provided an overview of changes instituted the hospital following Finlay's death. These included:

a. the employment of two full-time FACEMS in the ED;

b. changes to the structure of the Emergency Department Model of Care, so that an additional "mid-level" doctor is working during the day shift;

c. clearer indication as to the responsibilities of the senior doctor on shift in terms of reviewing all patients assigned to junior medical officers and monitoring documentation;

d. updating (in September 2021), the ED's Team Leader Orientation Package, so that a team leader maintains a "global perspective", incorporating high-grade critical thinking (in contrast to the clinical nurse who is cued into to the individual patient assignment and isolated task);

e. the auditing in June, July and August 2017 of five paediatric files to ensure compliance with the requisite NSW Health Policy Directive (that audit confirming the documentation to be compliant);

f. certain further training, including:

   i. in July 2017, several ward based in-services and a paediatrician presenting at the Hospital Grand Rounds regarding how to assess a child with a disability (attended by some 50 to 60 staff members);

   ii. on 8 September 2017, Ms Browne presented at the Hospital Grand Rounds regarding her experience of Finlay's care. The then Director of the ED also presented Finlay's case; and

g. the introduction of Patient Experience Officers, who have a non-clinical role seeking to improve communication between clinical staff, and families.

Evidence of Ms Jo Holden, General Manager BBH

386. The current GM of BBH, Ms Jo Holden, provided two further detailed remedial statements (dated 15 October 2023 and 17 November 2023); Ms Holden also gave evidence at the inquest on Thursday, 19 October 2023.

387. Holden attended every day of the inquest. This was valuable for the inquest, and a great comfort that this level of attention was being given to Finlay. Ms Holden had only been in the role of GM since February 2023. In her oral evidence, Ms Holden provided a

summary of her background in health care (which has included some 20 years working with vulnerable and marginalised people (for ACON, the Aids Council of NSW), and in senior leadership positions within the Ministry of Health). Ms Holden gave evidence that in discussing the role of GM with the Chief Executive, she understood they were looking for someone with experience around senior leadership, but also a cultural change.

388. In her initial statement, Ms Holden stated:

> The LHD accepts that there was a failure by senior Emergency Department medical staff to coordinate Finlay's care from the time the lactate result of 7 was known at 1800 hours, including liaising with the paediatric and surgical teams at an earlier time and in relation to liaising with NETS.

389. The changes and improvements nominated are as follows:

a. recruitment of FACEMs and increased efforts to retain staff, additional nursing staff and allocation of ED staff;

b. creation and implementation of the JMO Orientation Manual, the ED Medical Locum Orientation Manual and preparation of BBH's 'Escalation of Care Concerns' flow chart, and 'Executive on Call Information' pathway;

c. numerous NSW Health and WNSWLHD policy and process reform and implementation;

d. improving the culture of BBH to engage their "hearts and minds" and greater vision of training and information;

e. increased initiatives and training to ensure the provision of patient-centric care;

f. BBH being awarded with three years accreditation from the Australian Council of Healthcare Standards, following a National Safety and Quality Health Service Standards 2.1 Short Notice Assessment on 13-15 September 2023;

g. creation of the WNSWLHD Recognition and Management of Patient Deteriorating

h. preparation of a BBH 'Escalation of Care Concerns' flow chart and an 'Executive on Call Information' pathway; and

i. consideration given to preparing a case study of Finlay, in consultation with Rachel Browne.

390. Ms Holden was able to discuss reforms that have taken place, such as the visibility and acknowledgement of patient feedback and complaints, weekly meeting with the patient safety officer, the director of medical services, the director of nursing and midwifery and the manager of community health, training staff on unconscious bias and reviewing data of deteriorating patients and key performance indicators. As well as a 'Neonatal and Paediatric Seminar' provided by NETS to BBH staff in October 2022 – with consideration being given to future training sessions with NETS.

391. BBH has taken steps to secure additional funding to employ five full-time equivalent FACEMs in the ED. Ms Holden explained that as at October 2023, there were two FACEMs employed or otherwise engaged by the WNSWLHD to work in the ED of BBH. Ms Holden stated that these changes have had a positive impact on patients arriving at BBH ED; additionally, the changes to 'mixing' of staff in the ED has led to a significant upskilling in the clinical team.

392. However, Ms Holden reported the reality faced by regional areas in recruitment. She explained that the recruiting of medical staff was very competitive and that there is competition within the system, and within the district. Dubbo and Orange compete with each other for staff and local health districts, and then you have to compete with the - nationally as well. Ms Holden explained that BBH is quite locum dependant, and although engaging the same locums to ensure some continuity and then through that you also try to negotiate a fairer rate they may be outpriced in that process.

393. This is an important reality to note, and doctors are of course, and should be entitled to look for the best outcomes professionally that they can achieve. This evidence only strengthens the importance of access to external assistance, such as the resource of NETS.

Escalation of care

394. Tracey Wittich that the WNSWLHD "does not currently have an 'escalation pathway' to the on-call executive of the Local Health District" , as was the position in 2016, but that the LHD "is in the process of developing such a pathway". As to the current status of this "escalation pathway", Ms Holden's statement annexed the "Bathurst Health Service Escalation Pathway", a diagram with various arrows. Ms Holden noted that the pathway was being further updated and reviewed through BBH's local operating governance protocols.

395. There was no explanation for the delay in its preparation. The document itself is difficult to read, and not easy to follow or understand. It was conceded in evidence that it requires further work. Again after the obvious missing process identified in the evidence it is unfortunate that this has not been properly addressed these many years on.

Disaster management and competing surgical cases

396. As to the current contingency plan for BBH where there are two patients with urgent and concurrent surgical needs (for example, a critical surgical case and an emergency caesarean section) after making enquiries with the Director of Nursing and Midwifery and the Director of Medical Services, Ms Holden gave evidence that there is theatre nursing staff for one theatre only, with no recovery staff.

397. Ms Holden however noted that it was possible for another surgical team to be convened if there are two surgical needs. In terms of disaster management and convening two surgical theatres, Ms Holden said there was no disaster plan for more than one operating theatre although there is the on-call roster which the CNM is familiar with, and staff know when they are on call). She noted this is a rare occurrence, however in line with provided equivalent care to those in rural areas, Ms Holden noted her role she had identified gaps in current policies and procedures. Ms Holden stated that she was interested in formalising processes such as this.

Inter-hospital transfer arrangements

398. As to whether there existed a pathway or memorandum of understanding between hospitals within the WNSWLHD, Ms Holden could not recall a formal document, but referred to an escalation pathway to Orange Hospital. Her supplementary statement then confirmed that WNSWLHD was in the process of developing a local Guideline in

compliance with NSW Health Policy Directive PD2023_019 *NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements,* and had established an Inter Hospital Transport Pre and Post Specialist Care Collaborative Working Party, to lead the design and implementation of a District-wide Patient Flow System and Coordination. Additionally, the District level WNSWLHD Procedure WN_PD2020_004 vCare – *Referral of Children and Adolescents for Specialist Care and/or Transfer* was published in January 2020 and remains in place, currently under review.

399. Director of Medical Services and Clinical Governance of SCHN, Dr Mary McCaskill also prepared a statement for the inquest, which outlined a range of policy amendments and reviews conducted following Finlay's death. Dr McCaskill refers to three NSW Health policies which reflect the issues identified in Finlay's case that have since been updated following input from NETS and the SCHN:

    a. *Firstly*, NSW Health Guideline GL2017_010 *NSW Paediatric Service Capability Framework* published in 2017. LHDs are expected, pursuant to this guideline, to provide networked paediatric care, to link smaller hospitals within the LHD to those with more paediatric expertise. This guideline seeks to ensure that a paediatrician from within the LHD is available to all hospitals within that district for advice and support; further, it envisages that the clinician will work closely with NETS to align local and tertiary level advice. The paediatrician's familiarity both with their LHD and NETS should avoid the lack of clarity which appears to have occurred in Finlay's case. Further, this guideline identifies the responsibility of the LHD to provide escalating care for a patient who is deteriorating. The policy specifically identifies the need for support and advice for staff during the period waiting for the retrieval team to arrive.

    b. *Secondly*, NSW Health Policy Directive PD2023_019 *NSW Paediatric Clinical Care and Interhospital Transfer Arrangements* published in August 2023. Local Health Districts and Specialty Health Networks are to establish local arrangements for clinical consultation to support paediatric care for infants, children and adolescents delivered locally as well as escalation of care involving interhospital transfer. This policy also clearly sets out the role of NETS in providing expert clinical advice, emergency treatment and stabilisation and interhospital transport and/or retrieval.

c. *Thirdly*, NSW Health Policy PD2020_047 *Incident Management* published in December 2020. This policy details the review process following a serious incident. Since this policy, the SCHN has contributed to reviews in several LHDs involving NETS to ensure the complexities of retrieval are included in the review.

400. Ms Holden's supplementary statement confirms that the WNSWLHD is in the process of developing a local guideline in compliance with PD2023_019 (which does not specify local arrangements, but mandates that each District and Network develop local guidance for retrieval services and inter-hospital transfer arrangements). Ms Holden notes:

a. The LHD has established the Inter Hospital Transport Pre & Post Specialist Care Collaborative Working Party. The purpose of this Working Party is to lead the design and implementation of a District Wide Patient Flow System and Coordination response that is consistent and aligned with NSW Health policy and frameworks. The outcome of this work will focus upon the standardisation of processes and application of the tools and systems that underpin patient flow within and beyond the LHD.

b. At a District level Procedure WN_PD2020_004 *vCare – Referral of Children and Adolescents for Specialist Care and/or Transfer* procedure has been in place since January 2020. This procedure serves to provide a framework to facilitate safe and timely medical advice and/or Interfacility transfer of children and adolescent within the LHD whose medical condition requires a higher level of care and support. However, this policy is currently under review.

c. Ms Holden also advises that if there is a management plan for a patient from the Paediatric Team or some specific medical condition then, it is added as an 'Alert' to the patient's electronic file. This is usually completed by the speciality team.

Auditing of clinical documentation

401. Noting that only limited audits were conducted over a 3-month period in 2017 of paediatric files, Ms Holden took on notice the issue of broader, more recent audits. In her supplementary statement, Ms Holden provided the following further information:

> I have liaised with Dr Pavan Tumkur Phanindra, Director of the Bathurst Hospital Emergency Department, in relation to ongoing audits in this respect. Dr Phanindra advised me that he reviews all Emergency Department patient presentations daily, that he sees some of the presentations within the Emergency Department, that he reviews their stays at the Hospital where indicated and provides feedback to clinicians.
>
> I have further discussed the value of regular audits of documentation of Emergency Department paediatric patient files to ensure that clinical documentation met the requirements of NSW Health Policy Directive PD2012_069 Documentation and Management with the Bathurst Hospital Emergency Department Nursing Unit Manager. The Nursing Unit Manager has indicated that she would see value in regular audits. The Bathurst Health Service will undertake to explore a quality process to do this.

Lessons in clinical safety

402. Ms Holden's supplementary statement also noted that BBH executive has undertaken to lead discussions at the Bathurst Clinical Council meeting on 16 November 2023 to identify system improvement gaps such as escalation pathways, early identification of risk and coordination and communication of urgency, application of relevant guidelines and protocols, and scenario simulation training.

403. As to areas for improvement, A/Professor Lawton observed:

> I didn't see a great deal about escalation pathways and some of the issues we've discussed around sort of the hospital director and the lack of an EDMS mentioned in that document…

404. A/Professor Lawton further noted that:

> … but I absolutely, in fairness, would say that a lot of the issues that I thought came up in my report have been moved significantly on in the hospital's response.

405. BBH has recognised errors made in the care of Finlay, and taken steps to address these for the better care of other patients in the future. A significant change was the recruitment of FACEM, which was a clearly a significant and necessary improvement. This should give great comfort to the local community.

406. A/Professor Lawton too, was mostly positive about the significant changes instituted by the hospital since September 2017. The independence that A/Professor Lawton brought

to the inquest was very important, and reassuring in relation to the changes that have been made.

407. A/Professor Lawton also commented in evidence that, whilst is it difficult to capture the complexity of remediation in a document to a Court:

> … the hospital has moved, based on their comments, in that - a long way in the right direction so it's pretty clear that there's been a dedicated attempt to put some senior leadership into the ED which was one of the critical faults and to align the teams with service provision.
> …
> The piece I was interested in was the implementation assurance piece. There's certainly some excellent monitoring of adverse event reports that have come out that are attached to that document.

408. Additionally, the inquest benefited from hearing directly from Ms Holden, the new GM at BBH. Ms Holden was invested in the issue of improvement and very engaged. The inquest process is important for many reasons, and one of them is an opportunity for evidence gathering and learning. Ms Holden is a person in a position to continue to promote improvement and change, and she invested important time into the process, giving confidence that further changes can and will be achieved. She engendered confidence, she noted practical limitation and restrictions but demonstrated that her interest was working within those limitations and creating solutions. She was a very impressive witness.

Discussion of recommendations

409. Much of these findings reflect and incorporate thorough and detailed submissions of Counsel Assisting. The other interested parties did not make challenge to much of what was set out, and the focus was appropriately limited to addressing the recommendations proposed.

410. This approach reflected the approach of the interested parties throughout, and it was further evidence that the interested parties have acknowledged errors, and sought to engage in the coronial process mindful of making improvements and bettering systems that failed.

411. It is because of Finlay and his family that this opportunity was given to reflect on these very significant issues. Close attention was given in particular because of the regional nature of this case. Approximately 38% of our population lives in remote areas in New

South Wales, they rely heavily on the provision of medical services by local districts, and are entitled to as close to a level of care that they would access in metro areas. Of course there are limitations to this, but there are also solutions, resources and knowledge. NETS is an example of such a resource.

412. A number of recommendations have been recommended by Counsel Assisting, some have been embraced, others have been challenged.

PROPOSED RECOMMENDATIONS

413. The following are the recommendations proposed for consideration, and a discussion of the submissions and evidence that relate to each.

414. The following recommendations are proposed as being both necessary and desirable pursuant to s 82 of the Act:

Proposed Recommendation 1. To the Western NSW Local Health District (WNSWLHD):

a. That the WNSWLHD provide formal training to clinical staff on unconscious bias and how it influences clinical judgment, including as to persons with disabilities;

b. Related to (1)(a) above, that the WNSWLHD consider the potential utility of Exhibit 3: the Australian and New Zealand College of Anaesthetists & Faculty of Pain Management – *Unconscious bias toolkit* for the purposes of such training, and consider preparing a similar 'toolkit' for use by clinicians within the Local Health District;

c. That the WNSWLHD liaise with the Ministry of Health as to the review and revision process relating to the Policy Directive PD2017_001 *Responding to Needs of People with Disability during Hospitalisation* (January 2017) in relation to cognitive bias (noting the issues highlighted in these coronial proceedings);

d. That the WNSWLHD prepare an appropriate case study module as to the learnings arising from the circumstances of Finlay Browne's death for use in clinical teaching;

Proposed Recommendations 1(a) to 1(d) – Unconscious bias

415. Ms Browne gave evidence of the numerous examples of her experience of unconscious bias during Finlay's presentation at BBH. Ms Browne was shown the Australian and New Zealand College of Anaesthetists *Unconscious Bias Toolkit* (2023) and asked about the

utility of that document (with appropriate modifications) within BBH or the LHD. She addressed that as follows:

> I think so. I think that health does not teach unconscious bias. I think by the very involvement in people's lives, and marginalised people, cultural and linguistically diverse people, Aboriginal and Torres Strait Islander people, people with dementia, people with cognitive issues, that if we get it right for people like Finlay with intellectual disability, that we even get it right for people like myself with health literacy that are presenting to ED departments, because what hope have any of us got if I couldn't even activate the necessary assistance that my child needs.
>
> And I think we all harbour unconscious bias, and part of that is to reflect and observe that we have it and realise that in these situations that if we're not the best placed person to provide support and care that we then work as a team to ensure it happens, and I know that the Disability Royal Commission has handed out recommendations and, no doubts, my hope that a lot of those things resulting in health, particularly, will be upheld, but we still have a lot of work to do. And if there was training in recognising this in helping clinicians understand even how to speak to individuals with intellectual disability, physical disability, cognitive decline, and their parents, then that may traverse the gap slightly and assist with better outcomes.
>
> The one thing that has struck me about this is that I was with my son. I know him best. Nobody consulted with me. Nobody said to me once, Rachel, what do you think is happening? How is he appearing to you? Do you think he's in pain? It was obvious, as obvious as I sit here today, what was happening to Finlay. I don't think you would have had to be clinical to know, but all they had to do was ask, and I would have assisted in any way that I could because without the assistance of parents or mothers who know their children best, and often take their children to emergency departments, you're going blind, you're fumbling around in the dark. But in health we seem to navigate dealing with newborn babies that can't communicate. We deal with all manner of people. I don't understand why it is so difficult, and I don't understand why, throughout Finlay's life, I have had to make him relatable as a person.

416. Ms Holden was also shown the document, and she agreed it could be a template for a program or toolkit at BBH or the LHD, but noted:

> I think it would be important to understand if, so for example what is coming out of the Disability Royal Commission, what's already in place in the system, and is it being taken up and implemented well. I think it would be good to have that leadership from the broader health system around this particular issue, and then sort of also look at locally at what our are particular challenges at Bathurst for example, and what areas

> that we need to improve on, so I would - my preference would be this wouldn't - isn't a siloed effort.

417. Additionally, Ms Holden noted that it was "compellingly evident that it's a system issue", and agreed she would take the issue up with the Chief Executive of the WNSWLHD.

418. In her supplementary statement, Ms Holden advised that the WNSWLHD recognises the risks of all forms of bias to patient safety and provides clinicians with information on unconscious bias and encourages them to recognize their own unconscious biases by taking the 'Harvard Implicit Association Test' through Diversity Australia.

419. Noting the evidence referred to above, I accept that there is evidence of unconscious bias that impacted the care provided to Finlay in the ED at BBH leading to assumptions about Finlay being non-verbal, impacting where he was placed in the ED, the attention that he was given, observations which were not taken regularly, limiting interaction directly with him and assumptions about his pain levels, impacting upon his overall supervision, and his assessment. This may have in turn contributed to missing opportunities to earlier recognise the significance of his condition, and the deterioration he experienced. Ms Browne's evidence as to the prevalence of unconscious bias in health in her general experience as the mother of a disabled child is compelling.

420. By definition, the clinicians would not be cognisant of the extent to which such bias may have been operative in their interactions with Finlay or decision-making about him.

421. Ms Holden's supplementary statement notes the Harvard Implicit Association Test, and an "online training module" on Emergency Department Cognitive Bias, in support of the contention of that the "toolkit" already "form[s] part of the information accessible to LHD clinicians". The accessibility of such information to clinicians who may seek to access it (which appears to be wholly optional), is a very different proposition to the delivery of formalised, structured training.

422. The toolkit is a helpful, user-friendly document that could be readily adapted to inform a structured, and more formal training within the WNSWLHD. The fact that the Australian and New Zealand College of Anaesthetists and Faculty of Pain Management have as recently as 2023, identified the need for such a "toolkit" very much speaks to the broader issue of unconscious bias in the medical sphere.

423. The evidence supports that there are also broader learnings that should be considered in the review and revision of Policy Directive PD2017_001 *Responding to Needs of People with Disability during Hospitalisation* (January 2017) (as proposed in recommendation 1(c)).

SUBMISSIONS BY MS RACHEL BROWNE

424. Ms Browne provided short submissions to assist the inquest, and helpfully included the following evidence:

    a. National Roadmap for Improving the Health of People with Intellectual Disability (**the Roadmap**) (July 2021, Australian Government, Department of Health); and

    b. The Disability Royal Commission, Volume 6: Enabling autonomy and access, Chapter 4 'Health Care and Treatment' (**the DRC Report**), which, amongst other notions, references the above Roadmap.

425. In submission dated 6 April 2024, Ms Browne identified the following important matters:

    a. *First,* that it is recognised that people with intellectual disability have 2.5 times more health issues (noting there are around 450,000 people with intellectual disability in Australia);

    b. *Secondly*, people with intellectual disability have double the rate of emergency department and hospital admissions compared to the general population;

    c. *Thirdly*, people with intellectual disability represent four times the rate of avoidable hospitalisations; and

    d. *Fourthly*, people with intellectual disability represent more than double the rate of potentially avoidable deaths.

426. This is further evidence supporting the making of recommendations. Chapter 4 'Health care and treatment' of the Disability Royal Commission Final Report provides a number of 'Key points'. Those of particular relevance are:

    a. "We heard that the health system is complex and fragmented. Health services are not designed for people with disability and health workers do not have sufficient disability knowledge and skills. Negative attitudes can cloud decisions".

b. “Too often, people with disability have received poor care, the wrong care or no care. This is leading to poor health outcomes as well as trauma and distress...”.

c. “We must embed the right to equitable access to health services in the policy backbone of the health system – its national standards – and take a person-centred approach to the provision of care. We must ensure the health system is prepared to engage in preventive health care to reduce the higher risk of mortality for people with disability”.

427. Similar sentiments were powerfully articulated by Ms Browne during these coronial proceedings.

428. The DRC Report references the Roadmap (as released by the Australian Government in August 2021). Significantly, the Roadmap sets out a vison to reform the health system over 10 years to meet the healthcare needs of people with intellectual disability with key objectives of the Roadmap are to

a. improve support for people with intellectual disability, their families and carers,

b. develop better models of care for people with intellectual disability,

c. provide support for health professionals to help them deliver quality care for people with intellectual disability,

d. improve the oral health of people with intellectual disability, as a central requirement for improving their general health and overall wellbeing,

strengthen research, data and measurement to monitor the health outcomes of people with intellectual disability, and assess the effectiveness of initiatives in improving their health, and

e. improve emergency preparedness and response to ensure that the needs of people with intellectual disability are considered and met.

429. The DRC Report also notes that the Australian Government has committed to considering the findings and recommendations of the Disability Royal Commissioner in implementing the Roadmap.

430. Submissions on behalf of the WNSWLHD are very supportive of raising awareness of proper treatment of those presenting with disability and an awareness of unconscious bias, however do not support the making of recommendation 1(a) and (b). The concern raised is that the resources to develop and deliver a program and toolkit are considerable, the investigation process would necessarily be broad and the JMO are often short stay employees. The toolkits should be considered by the appropriate training body, such as by particular colleges, for example, the college of physicians, and the Australian Government is considering and responding to recommendations of the Disability Royal Commission.

431. The particular model adopted is ultimately up to the WNSWLHD, and can be as simple or complex as it is determined. Ms Browne raises the valid point that mere awareness that unconscious bias exists is a powerful way to combat it. Given there is often lengthy delays in implementation of Government recommendations, given the prevalence in our society of important community members with disabilities a good time to start is right now. Taking into account the submissions, I will make a slightly modified recommendation to what has been proposed.

432. In relation to 1(d), the submission on behalf of the WNSWLHD does not oppose the recommendation, but proposes that it not be made because it is not necessary to do so. During her oral evidence Ms Holden agreed that there are a number of critical learnings to be taken from Finlay's case and is happy to work with Mrs Browne to create case study. I think this falls outside of the ambit of the inquest in some respects, and on the evidence of Ms Holden it would seem that this will occur and I would assume any successor would also embrace this as an opportunity. Mandating a recommendation detracts from the collaborative approach that should be taken by the WNSWLHD.

Proposed Recommendation 1.

To the Western NSW Local Health District (WNSWLHD):

e. That as a matter of priority, the General Manager of Bathurst Base Hospital formalise a clear escalation pathway for on-call executive hospital support in circumstances of a major clinical incident within that hospital (including where there are two urgent, competing surgical cases after hours);

433. The WNSWLHD does not oppose and reflected on the executive statement of Ms Holden, who has already taken steps to achieve this recommendation. The WNSWLHD embraces an opportunity to liaise with the Ministry to ensure the broader learning as a result of the inquest are brought to the attention of the Ministry for its review and revision.

Proposed Recommendation 2.

Jointly, to the WNSWLHD and Sydney Children's Hospital Network (SCHN), on behalf of the NSW Newborn & Paediatric Emergency Transport Service (NETS):

a. That the WNSWLHD collaborate with SCHN and NETS to ensure there is appropriate training for emergency department clinicians on an ongoing basis (given transient staffing arrangements), regarding:
    i. Policy Directive PD2023_019 NSW *Paediatric Clinical Care and Inter-hospital Transfer Arrangements* (August 2023);
    ii. The general availability of NETS to provide expert clinical advice and medical assistance for:
        1. very sick or injured babies, children and adolescents up to the age of 16 years; or
        2. patients aged 16 to 18 years with chronic or complex conditions who have not completed transition to adult health services;
b. The benefits of early contact with NETS in relation to very sick babies, children or adolescents.

434. The WNSWLHD and SCHN oppose the making of the recommendation. It relies upon the fact that Ms Holden outlined that the Bathurst Health Service will discuss the potential for NETS to deliver specific training as part of the development of a multidisciplinary simulation training schedule for 2024 to improve teamwork skills across disciplines and departments in the management of various rapid response scenarios.

435. It is submitted that Ms Holden's responsibility is limited to Bathurst Health Service, not for WNSWLHD, and was not intending to discuss the potential for delivering of training on a broader basis.

436. There is concern raised concerning the capacity of NETS to provide such training. However I note the recommendation is seeking consideration of collaboration on training, not mandating nor expecting that NETS provide the training. There is information regarding NETS available in policy already. The evidence in this case does not support its effectiveness. On the evidence, a paediatrician might be more likely to be familiar with NETS, but the wider hospital did not seem to recognise the importance and use that it could make of NETS.

437. The recommendation is being proposed in broad terms. One of the most useful things to come from this tragedy is an opportunity to look at existing resources, and has highlighted how critical it is that there is a thorough understanding of the purpose of NETS. NETS should have been called sooner by the VMO, who did not appear to have the necessary understanding of that. Nor did the administration. There was also significant amounts of evidence that regional NSW relies on locums, and has a large number of short term doctors attendings at hospitals. Therefore the targeting needs to be clear and simple. These are simple suggestions, and after discussion with NETS and its vast experienced it should be thought that a very simple, quick and targeted education and be established. On that basis I propose to make that recommendation.

Initial Proposed Recommendation 3.

To the SCHN:

That there be urgent liaison with the Ministry of Healthy as to following matters being issues that deleterious impact on the provision of critical care services in children in NSW

a. Arrangements to ensure that NETS have priority access to a helicopter and their own fixed-wing aircraft;

b. Presently, five NETS teams rotate over a 24 hour period, compared to the previously instructed rotation of six NETS teams in a 24 hour period.

c. That consideration be given to increasing the age range of services provided by NETS, to infants, children and young people up until their 18th birthday.

In the alternative, Counsel Assisting's reply proposed the following course:

c. That the Working Group note and consider the concerns raised during the Inquest into the death of Finlay Browne as follows (being matters that deleteriously impact upon the provision of critical care services to children in NSW):

i. That consideration be given to ensuring the existence of appropriate arrangements for NETS to have priority access to a helicopter and a fixed-wing aircraft as necessary;

ii. That presently, five NETS teams rotate over a 24 hour period, compared to the previously instructed rotation of six NETS teams in a 24 hour period; and

iii. That consideration be given to increasing the age range of services provided by NETS, to infants, children and young people up until their 18th birthday.

d. That the matters in these submissions at [24](c) above, are not made by way of formal recommendation, but instead, are to be notified to SCHN by way of correspondence sent on her Honour's behalf.

438. The original proposed recommendation is opposed, SCHN submitted that NETS is part of a health service and it is therefore inappropriate that they own a fixed wing aircraft or helicopter. I understand this proposed recommendation is to facilitate NETS having priority access to both helicopter and fixed wing aircraft, not own or manage the same.

439. Further it is submitted that these matters are currently being addressed through better linkage between NETS and ambulance service to allow smooth flow of clinical information and the creation of a working party to achieve this. The SCHN is not opposing a recommendation that NETS be resourced to provide sufficient teams to address the need of the child population, it is raised that there are complexities in staffing further teams. Also that there is a role of NSW Ambulance Retrieval teams and AMRS in moving children, as demonstrated in this case.

440. This recommendation was supported strongly in evidence with Dr Carmo relating concerning evidence of the time taken to call and ask, indeed at times may I suggest, plead for a helicopter. In an environment where NETS requires two-thirds of the hours of use of aircraft, this is not a desirable practice. This need was clearly explained by the fact that NETS is required not only to recover the young people, or indeed babies, but that many times it is just as urgent to transport lifesaving equipment to them.

441. It is further noted that NETS typically provides advice and retrieval for children under 10, and that children over the 40 kilogram weight will normally require NSW Ambulance assistance. Finlay was retrieved by AMRS with no issues.

442. However, as was noted by the expert there was a hesitation in relation to Finlay in the initial consult due to his age.

443. One of the factors which Dr Carmo was very concerned with during the initial call related to his age, as she was aware that ordinary circumstances would mean the Children's Hospital would not take Finlay given his age. He would only be accepted normally if he was a patient of Westmead. It is easy to understand the confusion around this, patients who happen to be 16, who might be smaller, or perhaps like Finlay have a presentation with disability, or even be in their school uniform, yet taken to an adult ward and adult hospital. These matters were all raised in the inquest, and did impact on decision making, although for very good reasons exceptions were made for Finlay.

444. Submissions in reply by Counsel Assisting made the concession that the alternate proposal could alleviate the need for the originally proposed recommendation to be made, and instead the matter be referred to the working group that will be established to consider the needs of NETS.

445. I have considered the submissions, and intend to make a modified form of the recommendation in light of all submissions importantly those of the interested parties. The working group is yet to be established, the needs have clearly been identified at inquest, and should remain in the form of recommendation.

446. I agree that the evidence of Dr Carmo should be provided to the Working Group once it is established, and this request should be notified to the SCHN.

447. However, I have not extended this to making recommendations about rules relating to extending health services to capture 16-18 year old children. This issue affects more broadly the health system, both in relation to age of child for NETS and hospital intake. This was an issue that arose, but was somewhat peripheral, and given the limitations of evidence on this point I do not intend to make that a recommendation.

448. I do, however embrace the proposal by Counsel assisting:

iii. That consideration be given to increasing the age range of services provided by NETS, to infants, children and young people up until their 18th birthday. This is not made by way of formal recommendation, but instead, is to be notified to SCHN by way of correspondence, for the purpose of any working party consideration.

CONCLUDING REMARKS

449. None of the material assists heal the pain and suffering felt by Finlay's family. Finlay and his family however have assisted the community in drawing attention to those with disabilities presenting in ED. They have drawn attention to systems that were not working, or were not in place. They have created an opportunity for change and improvement, and on the back of distressing loss this family ensured matters were followed through, and that what went wrong has been identified, explored and repaired.

FORMAL FINDINGS

450. The following findings are made under section 81(1) of the *Coroners Act 2009* (NSW):

The identity of the deceased

451. The person who died was Finlay James Browne.

Date and place of death

452. Finlay died on 10 December 2016 at the Sydney Children's Hospital, Westmead, New South Wales.

Cause of death

453. The cause of Finlay's death was a mid-gut volvulus and bowel obstruction, leading to ischaemic bowel and related complications.

Manner of death

454. The manner of death was natural (in the context of issues concerning the adequacy of the care and treatment provided in the emergency department of the Bathurst Base Hospital on 30 September 2016).

RECOMMENDATIONS

455. Pursuant to section 82 of the *Coroners Act 2009* (NSW), the following recommendations are made:

Recommendation 1. To the Western NSW Local Health District (WNSWLHD)

a. That the WNSWLHD consider the provisions of formal training to clinical staff on unconscious bias and how it influences clinical judgment, including as to persons with disabilities;

b. Related to (1)(a) above, that the WNSWLHD consider the potential utility of Exhibit 3: the Australian and New Zealand College of Anaesthetists & Faculty of Pain Management – *Unconscious bias toolkit* for the purposes of such training, and consider preparing a similar 'toolkit' for use by clinicians within the Local Health District;

c. That the WNSWLHD liaise with the Ministry of Health as to the review and revision process relating to the Policy Directive PD2017_001 *Responding to Needs of People with Disability during Hospitalisation* (January 2017) in relation to cognitive bias (noting the issues highlighted in these coronial proceedings); and

d. That as a matter of priority, the General Manager of Bathurst Base Hospital formalise a clear escalation pathway for on-call executive hospital support in circumstances of a major clinical incident within that hospital (including where there are two urgent, competing surgical cases after hours);

Recommendation 2. Jointly, to the WNSWLHD and Sydney Children's Hospital Network (SCHN), on behalf of the NSW Newborn & Paediatric Emergency Transport Service (NETS):

a. That the WNSWLHD collaborate with SCHN and NETS to ensure there is appropriate training for emergency department clinicians on an ongoing basis (given transient staffing arrangements), regarding:
    i. Policy Directive PD2023_019 *NSW Paediatric Clinical Care and Inter-hospital Transfer Arrangements* (August 2023); and
    ii. The general availability of NETS to provide expert clinical advice and medical assistance for:
        1. very sick or injured babies, children and adolescents up to the age of 16 years; or
        2. patients aged 16 to 18 years with chronic or complex conditions who have not completed transition to adult health services;

iii. The benefits of early contact with NETS in relation to very sick babies, children or adolescents;

Recommendation 3. To the SCHN:

a. That there be liaison with the Ministry of Health as to the following matters being issues that deleterious on the provision of critical care services in children in New South Wales:
    i. Arrangements to ensure that NETS have priority access to a helicopter and fixed-wing aircraft; and
    ii. NETS to be resourced to provide sufficient teams to address the need of the child population noting that presently, five NETS teams rotate over a 24 hour period, compared to the previously instructed rotation of six NETS teams in a 24 hour period.

ACKNOWLEDGEMENTS

456. To the OIC – Buckley Cunich, who assisting in preparing an extensive brief, and followed through the matter diligently.

457. To the interested parties both representatives and department representatives who embraced this as an opportunity to reflect and make change.

458. To Counsel Assisting Ms Sullivan for her great attention to detail and excellent presentation of the case and submissions for the assistance of all, which in effect were adopted by all. To Solicitor Assisting Ms Heritage for her active support and careful, considered work throughout the inquest process.

459. My great thanks for the perseverance and input of the family of Finlay.

460. I extend my sincere condolences to Finlay's family for this significant, sad and tragic loss.

I close this inquest

Deputy State Coroner Kennedy

10 My 2024