CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 14th, 15th, 16th, 17th, 18th and 21st days of December 2015, the 7th and 8th days of January 2016, the 12th day of April 2016, the 14th day of June 2016, the 9th day of August 2016, the 3rd day of November 2016, the 12th, 13th, 14th, 15th and 16th days of December 2016 and the 22nd day of June 2017, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Leila Marijke Baartse-Harkin[1].

The said Court finds that Leila Marijke Baartse-Harkin aged 9 years, late of 2B Caldwell Street, Strathalbyn, South Australia died at the Strathalbyn and District Health Service, 14 Alfred Street, Strathalbyn, South Australia on the 1st day of October 2015 as a result of peritonitis due to perforated small bowel due to blunt abdominal trauma. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. On Thursday 1 October 2015 Leila Marijke Baartse-Harkin who was 9 years of age, born on 14 January 2006, was certified deceased at the Strathalbyn and District Health Service (the Strathalbyn Hospital). Leila's parents were Mrs Edith Harkin and Mr Ricky Harkin of Strathalbyn. Leila was their only child.

1.2. Leila attended the Eastern Fleurieu Primary School where she was in Year 3.

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[1] The deceased's birth certificate describes her as Leila Marijke Baartse, date of birth 14 January 2006. At the request of her parents Mrs Edith Harkin and Mr Ricky Harkin, Leila will be described herein as Leila Marijke Baartse-Harkin.

1.3. Leila sustained her fatal injury as the result of a fall from a swing that had occurred on the afternoon of Tuesday 29 September 2015 at an out of school hours care (OSHC) facility that was operated by the YMCA at Leila's school. The fatal injury was a perforation of Leila's small bowel. Despite medical attention following Leila's fall, including hospital attendances, and notwithstanding her overt unrelenting illness, this injury remained undetected and undiagnosed at the time of her death. How this came to pass was the principal issue examined in this Inquest.

1.4. Following Leila's death a post mortem examination involving a full autopsy was conducted by Dr Neil Langlois who is a consultant forensic pathologist at Forensic Science South Australia. Two reports compiled by Dr Langlois were tendered to the Court[2]. The first of those reports is dated 26 November 2015[3]. A second supplementary report is dated 30 December 2015[4].

1.5. In Dr Langlois' first report he cites the cause of Leila's death as:

> '1a) peritonitis
> 1b) perforated small bowel
> 1c) blunt abdominal trauma'

This cause of death is to be read as peritonitis due to perforated small bowel due to blunt abdominal trauma. I find that to be the cause of Leila's death.

1.5 The significant anatomical findings in respect of Leila were the existence of peritonitis within Leila's abdomen, the presence of a litre of fluid within the abdomen, a perforation of the small bowel, bruising to the anterior abdominal wall fascia and central mesenteric bruising. It is clear that these findings were the result of the fall that Leila experienced on 29 September 2015.

1.6 In his first report Dr Langlois asserts that a band of bruising across the fascia of the abdominal wall (deep to the recti muscles) and the deep bruising of the mesentery is indicative of blunt force trauma to the abdomen. Dr Langlois states that it is unclear how that injury would occur from a fall on a flat surface and that this finding suggests the involvement of a raised element on the ground such as a ridge or an object such as an arm being under the body causing local application of force. In fact Leila had also sustained a fracture to the left wrist as a result of the fall. As will be seen, Leila fell

[2] Exhibit C2a and C2b
[3] Exhibit C2a
[4] Exhibit C2b

from or jumped from the swing from a significant height and landed on bark chips on her front in the nature of a bellyflop. It is possible, if not highly likely, that at the time of impact her arm was trapped between the ground and her abdomen. It was suggested in some quarters during the Inquest that for that reason the brunt of the force resulting from the fall was necessarily absorbed by her arm or arms. To my mind one does not have to be a biomechanical engineer or medical practitioner specialising in trauma or emergency medicine to conclude that this suggestion is to be rejected.

1.7 Also within Dr Langlois' first report is the observation that there was evidence of a region of bruising of the small bowel at a point that could overlay the spine. He states that compressive blunt force to the small bowel can result in bleeding into the tissue and tissue damage. The bowel may be intact, but local swelling of the bowel wall due to the injury can result in narrowing of the intestinal lumen with consequent pain and vomiting. Dr Langlois asserts that the damaged area can subsequently break down resulting in a perforation and leakage of bowel content into the abdominal cavity. The escape of gut content into the abdominal cavity results in peritonitis and sepsis. It was the peritonitis that was the principal causative factor in Leila's death. These assertions might support a contention that the perforation of Leila's bowel was an event that occurred after an interval following the fall and was the result of breakdown of the damaged tissue. This scenario is to be distinguished from a bowel perforation that was sustained at the time of the original application of the force to Leila's abdomen. Expert opinion expressed in the Inquest differed as to which of the two scenarios should be preferred. This dichotomy, and its possible significance, was one of the issues examined during the Inquest. I would add here, however, that there is absolutely no doubt that Leila did sustain a serious internal injury at the time of her fall and that, whatever its precise nature at the time of the fall, the injury accounted for Leila's illness and her clinical presentation in the period between the application of trauma to her person and her death.

1.8 Dr Langlois was requested to furnish a supplementary report. In that report Dr Langlois refers to the evidence given in the Inquest by an independent expert, Dr Nicholas Rieger, who is a colorectal surgeon, and who in the course of his evidence expressed the very firm opinion that Leila had sustained the bowel perforation at the time of her fall from the swing. In Dr Langlois' supplementary report he states that he has read Dr Rieger's evidence and that he agrees that the perforation could have occurred at the

time of the fall. He does note that there appears to be a degeneration of the muscle layer of the small bowel in the region of the perforation and thus states that it is possible that there was an initial injury with subsequent break down and perforation occurring sometime after the fall. However, he says:

> 'I know of no method to determine from examination of the bowel which of the two possible scenarios (perforation at the time of the fall or a delayed perforation) occurred.'

He also adds that he '*knows of no studies that have data regarding the ageing of peritonitis*'. Dr Langlois' position on this issue can be summarised as follows:

> 'I have read Dr Nicholas Rieger's evidence. I agree the perforation could have occurred at the time of the fall. However, I note (when examining samples under the microscope) that there appears to be degeneration of the muscle layer (patchy necrosis of the muscularis) of the small bowel in the region of the perforation; thus, it is possible that there was an initial injury with subsequent breakdown and perforation occurring later. I know of no method to determine from examination of the bowel which of the two possible scenarios (perforation at the time of the fall or a delayed perforation) occurred.
>
> I know of no studies that have data regarding the ageing of peritonitis. If general principles of wound healing are applied, then the peritoneal inflammatory reaction would be in the order of one or two days old, which is of no use in addressing the question of the timing of the perforation.
>
> I am certain a significant bowel injury occurred at the time of the fall due to blunt abdominal trauma and that death was due to peritonitis as a consequence of this. However, in my opinion, there is no way of determining from the pathology with any certainty if the perforation occurred at the time of the fall or later. This is due to a lack of data for reference purposes and variation in reaction to injury such that it is not possible to determine the age of any injury with any certainty.'

1.9 Later in these findings I return to the issue as to whether or not Leila sustained the small bowel perforation at the time of her fall or whether it occurred later than that. I indicate here that I have found that the perforation was sustained at the time of the fall.

2. Background and reason for Inquest

2.1. It is convenient here to describe in general terms the sequence of events leading to Leila's death in order to provide a factual matrix against which the issues in this Inquest can be discussed. I deal with the salient events in greater detail later in these findings.

2.2. On Tuesday 29 September 2015 Leila attended OSHC vacation care provided by the YMCA at the Eastern Fleurieu Primary School in Strathalbyn. In her statement[5] Leila's

[5] Exhibit C1

mother, Ms Edith Harkin, explains that although she was not working that day Leila had nevertheless wanted to attend OSHC. Mr Ricky Harkin was working as usual during that day. Within the Eastern Fleurieu Primary School grounds there were sets of swings that were permitted to be used by children attending the OSHC service. Leila's fall from one of those swings occurred at about 1pm that day. The fall was not witnessed by any of the staff supervising the service but it apparently occurred in the presence of other small children. During the course of the evidence presented in the Inquest various estimates were given as to the height from which Leila fell. Much of it is naturally hearsay, although Leila herself would describe the height. It was believed that she had fallen from a height of between 8 feet and 10 feet. It has also been said that Leila had swung to a level that was at the height of the crossbar of the swing set which has been measured by police to be 2.8 metres. It has variously been said that Leila either deliberately jumped from the swing in order to pretend to fly or accidentally fell. I am not certain that the distinction is material because it is evident that she made contact with the ground with her abdomen in what has been described as a bellyflop.

2.3. Following Leila's fall she exhibited pain to both her wrist and her abdomen. She vomited at the OSHC service. Her mother was phoned and in due course she made her way to the school. No medical assistance was provided to Leila prior to Mrs Harkin collecting her from the school.

2.4. Leila spent the rest of that day at her home in Strathalbyn and was ultimately taken to the Strathalbyn Hospital that evening. In the intervening period it is evident that Leila experienced pain and vomited on a number of occasions and this led to her parents naturally becoming concerned about her.

2.5. Leila was taken to Strathalbyn Hospital by her parents at 10pm that night. She was there seen by a rostered general practitioner, Dr Man, who recommended that Leila be taken to the Women's & Children's Hospital (the WCH) for examination. Dr Man compiled a referral letter addressed to Paediatric Emergency at the WCH which stated among other things that Leila that day had jumped from a swing from a height of around 8 to 10 feet and had landed on her hands and abdomen. The letter recorded vomiting since that time. Dr Man also telephoned the WCH in advance about Leila.

2.6. Leila was driven by her parents from Strathalbyn to the WCH at North Adelaide. Leila's presentation at the Emergency Department at the hospital was recorded as

having occurred at 11:40pm. She was seen by the nursing staff at that time and was observed as being pale with a rigid abdomen and exhibiting significant pain. Leila was seen by a relatively junior paediatric trainee, Dr Amy McMellon, at 11:50pm. At about midnight, which was the time at which the x-ray department closed for the night, Leila was sent for a chest, abdominal and wrist x-ray.

2.7. The x-rays demonstrated no internal chest or abdominal abnormality but demonstrated that Leila had a fractured wrist. Nursing staff at the WCH placed her wrist in a backslab. A urine sample was also taken. No blood was taken from her. Certain observations were recorded by nursing staff which were abnormal and which were in a number of ways consistent with an internal abdominal injury. Only the one set of observations was recorded during Leila's attendance at the WCH.

2.8. Ultimately, Leila was reviewed by Dr McMellon and a senior Fellow, Dr Elissa Pearton, and it was at that time determined that Leila could be released. She was not admitted, even for observation. Accordingly, Leila left the hospital with her parents at approximately 1:30am. Leila's parents were not provided with any discharge document.

2.9. During the rest of that night and the following day Leila continued to exhibit worrying signs of serious illness and her mother was naturally concerned. Mrs Harkin made an appointment to see Dr Man, who had seen Leila at the Strathalbyn Hospital the night before, at Dr Man's practice in Strathalbyn. Leila and her mother attended at the practice shortly after 2:15pm that afternoon. Dr Man again saw Leila who reported significant stomach pain since returning home from the WCH from where she had been discharged the night before. Dr Man recorded that it was asserted during her appointment that Leila had undergone 'scans' at the WCH and that internal bleeding had been ruled out. The fracture to the wrist was noted. Leila was wearing the backslab. Dr Man did not perform any examination of Leila which she acknowledges was a significant failing on her part, a matter that I will return to in due course. All that really transpired at this appointment was the provision of reassurance from Dr Man with advice that Leila should take analgesia four times per day for continuous pain relief. Reasonably or otherwise Dr Man herself had felt somewhat reassured by the fact that Leila had been seen at the WCH the night before, by the fact that nothing serious had there been identified and by her discharge.

2.10. It is also evident that Leila's parents had also derived a false sense of reassurance from what had transpired with respect to Leila to date. She was taken home by her mother. From that point forward Leila still displayed worrying signs and symptoms. Towards dawn the following morning, Thursday 1 October, Leila entered into a state of extremis. She collapsed from the effects of undiagnosed peritonitis due to an undetected bowel perforation. Her parents quickly conveyed her to Strathalbyn Hospital where nursing staff had to be aroused by loud banging on the door and yelling on the part of her parents. By that time Leila was deceased or very close to it. Nursing staff came to their aid. Medical staff were also asked to attend at the hospital. Resuscitative measures that were employed for an extended duration were unsuccessful and Leila was certified deceased at 7:45am at the Strathalbyn Hospital.

2.11. The core question in this Inquest was why after her parents had sought medical assistance on three occasions following Leila's fall, two of which involved attendances at hospitals, Leila was not diagnosed as having sustained a significant and life threatening internal abdominal injury. The other matter for inquiry was whether if Leila had been diagnosed as having suffered a serious internal abdominal injury, her life could have been saved by timely surgery. This issue was the subject of extensive evidence. The issue as to whether Leila's life could have been saved at various points in time in the period between her fall and her death was examined. I have concluded that her death was preventable at different junctures during her fatal ordeal.

2.12. Leila's parents through their counsel, Ms Claire O'Connor SC, who came into this Inquest at a late stage, have invited the Court to be critical of the care that was provided to Leila by staff at the OSHC facility where Leila had sustained her fall. The criticism would have two asserted foundations, namely the contention that Leila's activities on the swings were not properly invigilated by an adult, and secondly that in spite of the fact that one of the staff members was a registered nurse, no medical assistance was sought for Leila in the period immediately following her fall.

2.13. In has to be said that these issues were not the principal focus of this Inquest. No evidence was led as to the nature of any duty of care, contractual or otherwise, that might exist in these circumstances. Accordingly, I make no specific findings about those matters except to record the facts surrounding them. With regard to the other issue involving the obtaining of medical assistance, this is a matter where opinions might legitimately differ as to whether, say, an ambulance should have been called in

the light of Leila's fall and immediate presentation, and called at a time before her mother had an opportunity to attend and make her own decisions in the best interests of her child. Alternatively, should Leila have been taken to the local hospital by staff? In the period immediately following the fall Leila was not overtly seriously ill. Notwithstanding that one of the workers at the OSHC facility was a registered nurse, who might have had a better understanding of the potential for serious injury from a fall from a height, the question is whether any person at the facility was in any better position to determine whether Leila required immediate medical assistance at a time before Mrs Harkin's arrival than was Mrs Harkin upon her arrival. I do not know the answer to that question and make no finding about the matter.

2.14. There was also an issue that arose in the Inquest as to the adequacy of the response from staff at the Strathalbyn Hospital to phone calls that were made by Mrs Harkin to the hospital in the hours before dawn on the morning of Leila's death. The suggestion in essence is that nursing staff at the hospital had been unduly dismissive of Mrs Harkin's concerns about Leila as expressed on the phone on two occasions that morning prior to Leila being brought to the hospital. It was not necessary to ventilate this issue to any significant degree. The reason for this is that evidence was given, which I accept, that by the time of the first such phone call was made by Mrs Harkin, Leila's condition had deteriorated to such an extent that it is almost certain that she was beyond successful surgical intervention at that point.

2.15. However, I do record that there can be no suggestion that Leila's parents Mr and Mrs Harkin did anything other than what was in Leila's best interests. In my opinion they cannot be viewed as having contributed to the death their child Leila. They did everything that they possibly could have been expected to do in order to ensure that Leila received appropriate medical care.

2.16. Both Mr and Mrs Harkin gave statements to the investigating police. Indeed, both gave statements on the morning of Leila's death. The statements are remarkable given that they were made in what could only be described as extremely harrowing circumstances. Mr and Mrs Harkin both gave oral evidence in this Inquest. They were extensively cross-examined. At the time the Inquest began in December 2015 Mr and Mrs Harkin were not represented by counsel. At the time they gave their oral evidence they were not represented. In due course they came to be represented by Ms O'Connor SC.

2.17. I carefully scrutinised the evidence of Mr and Mrs Harkin as it was given in the witness box. I observed their respective demeanours. I detected nothing to suggest that either Mr or Mrs Harkin were doing anything other than their best to tell the truth as they believed it to be. I accepted both of them as witnesses of truth. Both witnesses were prepared to make appropriate concessions when called upon to do so. It was evident to me that they both gave careful thought to their answers to questions. I compared their respective testimonies to that of each other and to the testimonies of other witnesses. There were, as would be expected, some differences in the accounts between Mr and Mrs Harkin and there were a number of inconsistencies between their evidence and the statements that they had provided prior to giving evidence on oath. There was also the odd occasion where I had to consider the possibility that their evidence may have been influenced by, as it were, a cross-fertilisation of ideas between them. None of these discrepancies or inconsistencies or other maters shook my belief that they were both witnesses of truth, doing their best to inform the Court of recollections honestly held.

2.18. In assessing the credibility of Mr and Mrs Harkin I took into account the fact that prior to them entering the witness box they had been present during the testimony of other witnesses and had both heard assertions from those witnesses with which they disagreed. There were instances where Mr and Mrs Harkin’s evidence markedly differed in respect of material issues from the evidence given by two medical practitioners who had already been called to give evidence. In this regard I saw nothing to suggest that either Mr or Mrs Harkin had chosen to deliberately tailor their evidence to evidence already given, or that in some other way their evidence had been influenced by what they had heard before they themselves entered the witness box. Mrs Harkin gave her oral evidence before Mr Harkin. Mr Harkin was not present in Court when Mrs Harkin gave her oral evidence.

2.19. In assessing Mr Harkin’s credibility in respect of matters in which his evidence differed materially from that of other witnesses, and where credit might therefore be an issue, I also had regard to the fact that he had a past history of offending.

3. Expert Evidence

3.1. A number of independent expert witnesses gave evidence in this Inquest. They were independent in the sense that none of them had a connection with the events with which this Inquest is concerned as those events had unfolded. However, as will be seen, in

one instance the expert was known to and had a professional association with one of the medical practitioners who was involved in Leila's care at the WCH.

3.2. The independent expert witnesses were as follows: Dr Nicholas Rieger, to whom I have already referred. Dr Rieger is a colorectal surgeon. Dr Rieger gave evidence inter alia as to the nature of Leila's internal injury and provided opinions as to whether or not Leila's death could have been surgically prevented at various points in time. Dr Ruben Sebben is a consultant radiologist who principally works at the Queen Elizabeth Hospital. He also conducts a limited private practice. Dr Sebben gave evidence about the utility of various radiological and other diagnostic modalities including x-ray, CT scan and ultrasound in the identification of internal abdominal injury including bowel perforation. Dr John Andrew Craven is a paediatrician and emergency physician who principally works at the Flinders Medical Centre. He also performs some work at the WCH. Dr Craven gave evidence concerning the appropriateness or otherwise of the management of Leila within the Paediatric Emergency Department of the WCH on the occasion in question. Dr Craven has an association with the WCH and has had a professional association with Dr Elissa Pearton who was one of the medical practitioners who saw and assessed Leila in the early hours of the morning of 30 September 2015 at the WCH. Dr Pearton cites Dr Craven as a referee on her curriculum vitae[6]. Dr Craven was called to give evidence at the instigation of counsel for Dr Pearton, Mr Bonig. The final expert witness who was called at the Inquest was Associate Professor John Raftos who is a senior specialist in emergency medicine at various hospitals in New South Wales. Associate Professor Raftos was employed as Director of Emergency Services at the Sutherland Hospital from 1984-2006. He has a conjoint associate Professorship of medicine at the University of New South Wales. Associate Professor Raftos gave evidence concerning the appropriateness or otherwise of Leila's management within the Paediatric Emergency Department of the WCH. Associate Professor Raftos was called to give evidence at the instigation of counsel for Mr and Mrs Harkin, Ms O'Connor SC.

3.3. I regarded all of those witnesses as experts in their respective fields.

[6] Exhibit C15

3.4. I also regarded the two medical practitioners who assessed Leila at the WCH on the occasion in question, Dr Elissa Pearton and Dr Amy McMellon, as experts in their respective fields.

3.5. I had due regard to all of the evidence and to all of the opinions expressed by each of those medical practitioners. A number of members of the nursing staff at the WCH were also called to give evidence. Insofar as those witnesses expressed opinions on clinical matters, I regarded them as experts in their respective fields.

3.6. Dr Sue-Yin Man, the medical practitioner from Strathalbyn who saw Leila twice prior to her death, is a general practitioner of several years standing. Insofar as Dr Man in the course of her evidence expressed medical and clinical opinions, I regarded her also as an expert in her chosen field of medicine.

4. Leila's fall

4.1. The height from which Leila fell is an important issue as it relates to the force of the impact that she sustained. So is the part or parts of Leila's body that came into contact with the ground.

4.2. At the Strathalbyn school a transportable classroom is utilised for OSHC purposes. There is also a playground that has swings and other play equipment. The swings are located approximately 30 to 40 metres from that building. There does not appear to have been any restriction on children of Leila's age using this equipment. That afternoon one of the educators, Mr Michael Elliott, was at the playground. His statement[7] reveals that he received a message via two-way radio that Leila had been involved in an incident at the swings. Mr Elliott suggests that he was about twelve metres away from that position when he received the notification. His focus had not been on the swings. He walked towards the swings and observed Leila on the ground just to the front of a set of swings. He describes Leila as being '*huddled over on her side*'. At about that time another worker by the name of Vicki Trebilco arrived on the scene.

4.3. Mr Elliott's statement asserts that Leila looked as if she had been winded and that she was wheezing and crying. It appeared that she was having difficulty breathing. Mr Elliott states that Ms Trebilco helped Leila up and escorted her back to the OSHC

[7] Exhibit C5a

room. Later he observed Leila on a couch. She was holding ice to her wrist and was watching a movie. He asserts that she was quiet but otherwise seemed alright. In due course Mrs Harkin arrived to collect Leila.

4.4. Ms Trebilco, who is a registered nurse, provided a statement[8] and gave oral evidence at the inquest. She had also compiled a written report in relation to the incident. In her report Ms Trebilco recorded that Leila had been playing on the swings at the playground and had '*jumped off and landed on her belly*'[9]. She recorded that Leila had winded herself. Ice was applied to a possible injury to Leila's wrist. In her witness statement Ms Trebilco asserts that her attention was alerted to the incident at about 1:00pm. At that time she was dealing with another child in the OSHC room. She was approached by some children who told her that Leila had jumped off the swing and had hurt herself. She went to the location of the swings where she found Leila sitting against one of the legs of the swing set. Leila was holding her right wrist against her stomach and was crying. Ms Trebilco asked Leila what had happened and Leila said that she had jumped off and had landed on her belly. She also said that she had hurt her wrist. Ms Trebilco then took Leila to the OSHC room where Leila was placed on the couch and provided with ice for her wrist. Ms Trebilco checked her abdomen which was slightly red but not abraded. Leila appeared to be breathing normally and had stopped crying but still complained that her stomach hurt and that her wrist was sore. Mrs Harkin was phoned at about 1:40pm and a message was left. At about 2:15pm Mrs Harkin returned the call and said that she would collect Leila in about 30 minutes. In due course Mrs Harkin arrived to collect Leila. In the meantime Leila appeared to be resting comfortably on the couch. She was talking to other children and was watching a movie. At about 2:55pm Leila told Ms Trebilco that she could no longer remain on the couch as it was too noisy and that she felt sick. She said that she wanted to throw up. She walked across to the toilet where she vomited. About the same time Leila's mother arrived. Once she finished vomiting she collected her things. On the way to the car she again vomited. Ms Trebilco offered advice to Mrs Harkin that if Leila's stomach became hard or started to swell she should take Leila to see a doctor.

4.5. In her oral evidence Ms Trebilco provided further detail as to her understanding of the nature of Leila's fall. She told the Court that the children had advised her that Leila

[8] Exhibit C13a
[9] Exhibit C13

had jumped from the swing and had fallen flat on to her stomach. Leila herself indicated the particular swing to Ms Trebilco. Leila also told Ms Trebilco that she had jumped from the swing and had landed on her belly with her arms on either side of her, describing it '*like she*'*d done a belly whacker into a pool*'[10]. Ms Trebilco told the Court that the surface below the swing consisted of bark chips. Ms Trebilco demonstrated the position which she understood Leila had been in when she had made contact with the ground. She indicated to the Court that her hands had been either side of her head with her palms forward. Leila said that her tummy was sore although there was pain to one of her wrists, the main focus of her pain being her abdomen. Asked as to her impression as to the height from which Leila had jumped, Ms Trebilco told the Court that she asked Leila if she had been trying to be Superman or Batman to which Leila had said that she was trying to fly. From this Ms Trebilco deduced that the swing would have been at a significant height at the time Leila commenced her descent to the ground[11].

4.6. Ms Trebilco said that at first she simply believed that Leila had been winded. Leila had interacted with other children following the event, had watched a movie and had giggled. When Leila had said that her stomach was still sore and that her wrist hurt, Ms Trebilco decided to contact Leila's mother.

4.7. Ms Trebilco also told the Court that after some time Leila became quite distressed and was vomiting. She was crying and asking for a doctor. At about that point her mother arrived. In her oral evidence Ms Trebilco reiterated the assertion contained in her witness statement that she advised Mrs Harkin that if Leila's stomach became hard or started to swell she should see a doctor. As a registered nurse she had it in her mind that these might be signs of an internal injury.

4.8. Mrs Harkin's first witness statement[12] was taken by investigating police very soon after Leila's death on 1 October 2015. In this statement Mrs Harkin told police that Ms Trebilco had told her that Leila had jumped from the swing and had belly flopped. Mrs Harkin confirms that when she arrived at the OSHC building Leila was in the toilet vomiting and she also confirmed that Leila vomited as they walked to the car. Leila vomited on a number of occasions that afternoon and evening and complained of stomach pain.

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[10] Transcript, page 25
[11] Transcript, page 39
[12] Exhibit C1

4.9. In a subsequent statement taken on 3 November 2015[13] Mrs Harkin asserted that Ms Trebilco told her that Leila had belly flopped from the swing at a height of around 8 to 10 feet. It will be remembered that police measured the height of the cross bar at 2.8 metres which converts to 9.18 feet. In that same statement Mrs Harkin asserts that Leila herself explained to her what had happened. Leila said that she had jumped off the swing and had landed on her stomach. Mrs Harkin also asserts that on 9 October 2015, which I understand was the day of Leila's funeral, one of the children who had been present at the OSHC facility on the day of Leila's fall told Mrs Harkin that Leila had been standing on the swing when she jumped off.

4.10. In her evidence Mrs Harkin told the Court that Leila's account of what had happened matched that of Ms Trebilco. She understood from the information that she received that Leila had jumped from the swing at a height of about 10 feet[14]. Mrs Harkin said that she subsequently gave this account to the nursing staff at the WCH as well as to the first doctor who saw Leila. She also said that Leila herself had provided information to the clinicians that was consistent with what Leila herself had already said about the incident. It was also consistent with Mrs Harkin's own understanding of what had taken place.

4.11. When Leila was taken to the Strathalbyn Hospital that evening, which was the first occasion on which medical assistance was sought, Leila indicated to Dr Sue-Yin Man that she had fallen from a height estimated by reference to the ceiling of the emergency room of the hospital which Dr Man assessed as being about 10 feet or 3 metres in height which is 9.84 feet. Dr Man recorded in the Strathalbyn Hospital progress notes that Leila had fallen off a swing from a height of 8 to 10 feet, and that she had experienced abdominal pain since the fall. She noted a discharge diagnosis of '*? blunt trauma*'. The estimated height of 8 to 10 feet would feature in the doctor's referral letter to WCH. In her oral evidence before the Court Dr Man stated that her greatest concern about Leila was the height from which she was understood to have fallen[15]. Specifically, she was concerned that Leila may have sustained intra-abdominal pathology such as a laceration to the spleen or a rupture of the bowel.

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[13] Exhibit C1b
[14] Transcript, page 394
[15] Transcript, page 325

4.12. The understanding gained by the triage nurse at the WCH immediately on Leila's presentation with her parents at approximately 11:40pm that night was that Leila had jumped off a swing at after school care as she had wanted to see how high she could jump. She understood from information that was imparted to her that Leila had landed on her stomach and her hand. That evidence was given by registered nurse Ingrid Sanders who was the triage nurse on duty that night. Ms Sanders said that this information came from Leila's mother. She told the Court that she was not provided with a figure as to the height, but '*just was told that it was high*'[16].

4.13. The second member of nursing staff at the WCH to see Leila was registered nurse Nicole Defrancesco. Ms Defrancesco recorded Leila as having fallen off a swing from a height of between 8 and 10 feet onto her abdomen then hands and knees. She told the Court that this information was an amalgam of three sources of information, namely the patient, her mother and the contents of Dr Man's referral letter[17]. Ms Defrancesco also told the Court that she advised the first medical practitioner who saw Leila, Dr Amy McMellon who was the paediatric registrar, that Leila had potentially fallen from a great height. She said that when she had asked Leila and her mother about that height they pointed to a moveable light that was hanging from the hospital cubicle wall, which was a height of about 2 metres. 2 metres is 6.56 feet[18]. Ms Defrancesco also told the Court that she definitely recalled mentioning twice to the doctor that Leila had fallen from a height. Ms Francesco stated that she was certain of this because she believed that the height was an important factor and also by virtue of the fact that Leila was in a lot of pain at that point. Ms Defrancesco gave the following evidence:

'Q. Leila gave you a description as to how she had come off the swing.

A. Yeah, so I had to ask a couple of times how that happened because at first I was a little bit unsure at which point did she fall off the swing. So I managed to get that information from mum and Leila.

Q. What did you understand from speaking to both Leila and her mother as to how Leila had come off the swing.

A. So she had jumped off at one of the highest points of the swing, when the swing was elevated and landed on her abdomen and her hands and knees.

Q. How did you understand her hands, that she had on hands.

A. With her hands out.

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[16] Transcript, page 554
[17] Transcript, page 55
[18] Transcript, page 65

> Q. So did she have her hands out in front of her when she on the ground.
>
> A. I believe so but I can't recall yeah.
>
> Q. What part of her body did you understand took the full force of the fall.
>
> A. Most likely her abdomen and hands.'

If Leila had in fact jumped off at one of the highest points of the swing she could have fallen from a height of 2.8 metres.

4.14. Ms Defrancesco also gave evidence that she pointed out the light and its height to Dr McMellon. She reiterated that she had believed that it was important that Dr McMellon understand the height '*because it was a high fall and I guess the effects of potentially what could happen, given if she had abdo trauma*'[19].

4.15. Another registered nurse Chloe Basford, who was to accompany Leila and her parents to the x-ray department, also gave evidence that Ms Defrancesco told her that Leila had fallen from the highest point of the swing[20].

4.16. Notations from the clinical record made by Dr Amy McMellon at the WCH appear to amount to a conglomeration of information that she gleaned from her assessment of Leila. I found this note difficult to comprehend. The same applies to much of Dr McMellon's evidence about her understanding of the height from which Leila fell and the part or parts of Leila's body on which she fell. Dr McMellon's notes have alterations and in any event the information that the note records seems to be at odds with Dr McMellon's evidence as to what she had understood about the fall. Unfortunately, therefore, it is necessary to spend a little time dealing with this topic.

4.17. Dr McMellon's note appears to have been crossed out in part and then added to, but in essence it records that Leila jumped off the swing and fell to the ground and that she landed with her arms outstretched and had hurt her abdomen. It records pain since the injury and that she had vomited on multiple occasions. What appears to have been crossed out is a notation to the effect that she was unsure whether she had landed onto anything '*on abdo*'. An additional note suggests that Dr McMellon recorded that Leila's arms had been bent and that she had landed flat on her abdomen onto bark chips

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[19] Transcript, page 77

[20] Transcript, page 823

from the highest point of the arch of the swing. There is a note querying whether that was from a height of 2 metres.

4.18. When Dr McMellon gave evidence she told the Court that Leila had told her that she had fallen off the swing and that when she fell she landed with her arms outstretched and then they bent and that she then she landed on her abdomen[21]. Dr McMellon explained the alteration to her notes, stating that after Leila had her x-rays, she had more time and so she '*redid my history*'. That explained why she had crossed out certain things and had changed her note to reflect how Leila had landed on bark chips and how Leila thought that the height of the swing and the point at which she had come off was at least a little bit taller than Dr McMellon. She had then questioned Leila whether or not that height was 2 metres or less. Dr McMellon also attempted to explain that the uncertainty as reflected by her altered notes surrounded the type of surface that Leila landed on. However, there had been no uncertainty about how Leila had landed, namely with arms outstretched and then on to the bottom of her chest and the front of her abdomen. That was also where her pain was situated. In cross-examination Dr McMellon reiterated that her understanding had been that Leila's arms had struck the ground first and that this impact was followed by the chest and her abdomen. Leila did not say what the height from which she had fallen had been, but they had estimated that it was a height at least as much as the height of Dr McMellon herself, possibly a little bit taller, such that it had to be less than 2 metres. Dr McMellon stated that she is 1.64 metres in height. When asked as to whether the nursing staff had said that Leila had fallen from approximately the height of a lamp in the cubicle, Dr McMellon said that she could not remember this. She suggested, however, that the lamp would be at least, and perhaps more than, 2 metres from the floor, and in any case significantly higher than the top of her head.

4.19. There is no note anywhere in the clinical records of a suggestion that the height of the fall was significantly less than 2 metres, or could be measured by reference to Dr McMellon's own height. Dr McMellon's own note suggests that it was understood by all clinical staff to that point that Leila had fallen from the highest point of the arch of the swing which we know to be 2.8 metres. Dr McMellon did agree that if Leila had

[21] Transcript, page 98

fallen from a height of 2 metres it would have been a significant fall[22]. Asked as to how she would categorise the fall as she had understood it to be, she said:

> 'I had it more as a - that she was on a downward angle taking the force and that it hadn't been particularly high, that it had been maybe my height which isn't too high for her size.'

She said that she would categorise a fall from such a height as at the lower end of moderate[23]. Asked to explain her entry within the notes, namely '*(?2m)*', she said:

> 'We tried to work it out with Leila and that she thought she was on the way up from what I could work out with her. So whether or not it was the highest arch of the swing versus on the way up, it was at some point - so I went with what would be potentially the worst, at the highest arch, less than 2 m, at the most two.'

4.20. Dr McMellon told the Court that she did not read Ms Defrancesco's notation that Leila had fallen off the swing from a height of between 8 to 10 feet and had fallen onto her abdomen and then her hands and knees[24]. Her own impression was that Leila's hands had broken her fall to a certain extent[25] and that she had obtained that impression from Leila herself. This analysis appears to fly in the face of Dr McMellon's own notation that states that Leila had landed flat on her abdomen from the height of the highest point of the arch of the swing. Notwithstanding all of this, Dr McMellon said that she did not think that Leila had taken the brunt of the force on her abdomen[26]. When Dr McMellon was recalled to give further evidence (almost a year after the first occasion on which she gave evidence, in circumstances I will later describe) she was cross-examined by counsel for Mr and Mrs Harkin about the height of the fall. She reiterated that she did not believe that the height was greater than 2 metres and that Leila had landed on her arms and then her abdomen.

4.21. In the event, Dr McMellon was asked by Dr Pearton's counsel, Mr Bonig, whether in terms of any abdominal injury Dr McMellon had attached any significance to the manner in which Leila had fallen and to the height from which she had fallen, and what she had fallen onto. To this Dr McMellon suggested that they could not have been certain about the height except that it was '*about the same height as me*' and that it had been onto bark chips with nothing firm or hard underneath. To her mind this had given rise to a low suspicion that anything significant in the way of an internal perforation

[22] Transcript, page 183
[23] Transcript, page 184
[24] Transcript, page 210
[25] Transcript, page 211
[26] Transcript, page 212

had been sustained. If anything, she suggested that the manner in which she had fallen had been reassuring. There had been no marks or blemishes on Leila's stomach or chest and that had made her think that the force she had landed with would have been reasonably low. She had thought, in light of the arm injury, that perhaps the arms had taken the majority of the force. To my mind this analysis at best could be said to reflect wishful thinking on Dr McMellon's part or at worst amounts to a conscious and deliberate revisitation of what she had believed at the time. Having regard to Dr McMellon's own notations, the notations of others and what was generally understood about the circumstances of Leila's fall, I do not believe that Dr McMellon was in any sense reassured either by the height from which Leila was believed to have fallen, by the part or parts of Leila's body that had broken her fall or by any other circumstance connected to the fall. Every piece of information gathered to the point in time at which Dr McMellon assessed Leila had been to the effect that Leila had fallen from a significant height, that the majority of the impact had been sustained to her abdomen and that Leila had experienced significant pain to that part of her body since the event.

4.22. In the event I have preferred the scenario created by the totality of the notes that Dr McMellon compiled in relation to the circumstances in which Leila was said to have fallen to her oral evidence about her understanding of that issue. The description as contained within the Dr McMellon note of Leila landing flat on her abdomen from the highest point of the arch of the swing, possibly from a height of as much as 2 metres, to my mind is inconsistent with Dr McMellon's assertions as contained in her oral evidence before the Court that the manner in which Leila had fallen was '*reassuring*[27]' and that the force with which she had landed '*would have been reasonably low*[28]'. Dr McMellon's oral descriptions of what she may have deduced about the fall was not consistent with descriptions that had already been given to Dr Man in Strathalbyn and to the nursing staff at the WCH. It will be remembered, and I accept her evidence on this, that Dr Man's principal concern was the height from which Leila was said to have fallen and the possible internal injuries that may have resulted from that. I have found it difficult to understand why the concerns of another medical practitioner would have

[27] Transcript, page 161
[28] Transcript, page 162

been so readily sidelined and why a paediatric registrar in an emergency setting would not have assessed Leila in the same way.

4.23. The issues surrounding the circumstances in which Leila fell was also the subject of evidence given by Dr Elissa Pearton who was the Fellow who ultimately authorised Leila's discharge. I will come to Dr Pearton's evidence in some detail in another section of these findings, but it is as well to deal here with the issue of Dr Pearton's understanding of the circumstances of the fall. Dr Pearton made no note in relation to her examination of or assessment of Leila that was included in the progress notes in respect of Leila's attendance. However, on the day of Leila's death Dr Pearton was instructed by a superior to compile an ex post facto note of Leila's attendance and her examination. This note was seen by this Court for the first time at around the commencement of this inquest. The note is compiled on WCH progress notes proforma sheets and includes reference to the UR number for Leila's file. Notwithstanding this, the note never made its way into the formal records of the WCH or was provided to the Court in response to the direction to the WCH to produce its records relating to Leila. Dr Pearton through her counsel also provided a witness statement dated 11 December 2015. This statement was provided prior to Dr Pearton giving her evidence. The statement consists of 10 pages.

4.24. Dr Pearton's handwritten notes on progress note letterhead contain, among other information, what purports to be an account of the circumstances surrounding Leila's fall. It states as follows:

> '9 year old female – attends PED with parents
> At child care today
> On a swing – jumped off swing/fell landing
> On her L outstretched arm
> On further questioning denies landing on
> her chest or abdomen, denies being
> hit in her chest or abdomen with the
> swing.'

Dr Pearton's witness statement asserts that she had asked Leila to tell her what happened and that Leila had simply said that she had fallen off a swing. Dr Pearton had then asked her '*did you fall off the swing or did you jump off the swing?*' and Leila said '*well, I jumped but I fell.*'. Dr Pearton had then asked her '*did you fall on your chest?*' to which Leila had replied '*no*'. Dr Pearton had then asked '*did you fall on your*

tummy?' to which Leila again said '*no*'. Dr Pearton had then asked '*did you fall with your arms out?*' and Leila had replied '*yes*'. The statement also asserts that Dr Pearton had asked whether the swing had hit her chest or tummy or whether she had landed on anything when she went on the ground to which Leila had said '*no, just my arms*'.

4.25. It is common ground that any conversation that Dr Pearton had with Leila occurred in the presence of both of her parents and Dr McMellon. If Dr Pearton's account of her conversation with Leila is correct, what Leila said was inconsistent with everything that had been said about her fall to date. In particular, Leila's denials that she had fallen on her stomach or her chest contradicted everything that had so far suggested that she had in fact fallen on the front part of her body. Yet no one present corrected Leila, especially her mother. And of course, if Leila had denied that she had fallen on her chest or abdomen it would have begged the obvious question as to what part of Leila's body she did in fact fall on. The notion that she could merely have fallen onto her arms is patently absurd. Some other part of her person must also have experienced an impact with the ground. In any event I view the notion that Leila's fall was broken by her arm or arms and that this would have resulted in minimal force being applied to her torso as quite ridiculous and totally out of keeping with human experience.

4.26. I have rejected Dr Pearton's evidence concerning her conversation with Leila. To my mind it is highly unlikely, if not completely implausible, that Leila at the eleventh hour would have denied the very things that had been well understood to have occurred to her, have denied them in the presence of her mother in particular and that nobody had corrected what she had said to Dr Pearton.

4.27. Having carefully considered the matter, to my mind the evidence is manifest that Leila had either jumped or fallen, it makes little difference which, from the swing at a height of 2 metres or more and had landed with a significant impact on her chest and abdomen. I so find. Dr Man's concerns were well placed. The suggestion that Leila had fallen from a height of this magnitude and had landed with force onto her abdomen was a matter that clinicians needed to have very careful regard to in assessing whether Leila had sustained a serious internal injury. Whether her arm was injured as a result of it striking the ground first is a matter that I will discuss in due course.

4.28. I also find that the description given to nursing staff at the WCH, and as understood by Dr McMellon, was that she had fallen with significant force from a significant height

onto her chest and abdomen. This was a matter that should consistently have been viewed as a worrying circumstance. If this version of events became less clear as Leila's attendance and presentation at the WCH progressed, (although in my view it did not) clinical staff at the WCH should have acted on a worst case scenario basis that Leila had experienced a significant impact to her chest and abdomen as a result of a fall from a significant height.

5. The timing of Leila's bowel perforation

5.1. What turns on this issue is whether or not Leila was suffering from peritonitis at the time of her presentation at the WCH. For the reasons that follow, I have found that she was.

5.2. On this subject I have already referred to the evidence of the forensic pathologist Dr Langlois. To my mind Dr Langlois' evidence is neutral in relation to that issue. Nothing that Dr Langlois has said in either of his reports precludes the notion that Leila sustained her bowel perforation at the time of the impact.

5.3. On this subject there was a deal of evidence given by Dr Nicholas Rieger to whom I have already referred. Dr Rieger provided a report to the inquest dated 30 October 2015[29] and he gave oral evidence.

5.4. I have already referred to the fact that Dr Rieger is a colorectal surgeon. Dr Rieger is an Associate Professor in Surgery at the University of Adelaide and at the Queen Elizabeth Hospital. He was the Senior Consultant Colorectal Surgeon at the Queen Elizabeth Hospital between 1999 and 2015. He has been a Senior Consultant Colorectal Surgeon at the Royal Adelaide Hospital between 1999 and 2006. He has been a visiting surgeon at the WCH since 2000. His position at the WCH gives him with the right to work within that hospital, which he does exercise on an irregular basis, and to assist in surgical care in the treatment of bowel disorders in paediatrics. Dr Rieger has a private practice in which he sees children and adults. Dr Rieger told the Court that on occasions at differing institutions he has had to attend paediatric emergencies in a surgical capacity. He has operated on children with traumatic bowel perforation. He stated that over the years he has operated on children in many settings including for blunt trauma, penetrating trauma, gunshot wounds and knife injuries. He has performed emergency

[29] Exhibit C20a

procedures for traumatic injury of the bowel. I regard Dr Rieger as an expert in the field of colorectal surgery.

5.5. Dr Rieger was asked to explain the mechanism of the injury that Leila sustained. Dr Rieger answered by reference to photographs that had been taken at Leila's post mortem which included a depiction of the fatal injury to the small bowel. Having regard to the history that was given in respect of the swing incident, and to the report that she had landed on her abdomen, Dr Rieger suggested that Leila had either landed flat on her abdomen or had landed across something which could well have been the left arm that was fractured. He said:

> 'The mechanism I would suggest as the cause for the small bowel injury is a compression injury, so it's been crushed against the vertebral column with considerable force and that's caused a blowout or crush injury to the small bowel, and a perforation at that time.'

As to whether the perforation had occurred at the time of the swing incident or whether it had occurred subsequent to that, Dr Rieger said that the clinical circumstances and the manner of injury would suggest to him that Leila's was not an injury that had culminated in a perforation after the event. He said that the appearance of the injury was not in keeping with that scenario because the affected area did not look as if it had been bruised or had a massive haematoma related to it that could have subsequently broken down. Dr Rieger said that the hole in the bowel looked relatively clean and punched out. The rim of the hole looked relatively tidy and that it did not look *'all busted and bruised'*[30]. Dr Rieger's view was that it was a blowout or burst type injury that occurred at the time of the fall[31]. There was a second limb to Dr Rieger's opinion that the perforation had occurred at the time of the accident. He suggested that this was an even stronger consideration, based as it is on the number of hours between the impact from the fall and Leila's death. Dr Rieger was of the opinion that if the perforation had been a subsequent evolving event, the time scale would have been different insofar that in his view she would have died at a later time. He said '*so I am basing my opinion on how clinically she progressed more so than anything else*'[32].

5.6. Dr Rieger was asked to comment on Dr Langlois' assertions concerning the timing of the perforation. To this Dr Rieger maintained his view that based on the appearance of the perforation and the timeframe between injury and death Leila's bowel perforation

[30] Transcript, page 454
[31] Transcript, page 454
[32] Transcript, page 455

occurred at the time of the impact. He agreed with Dr Langlois' suggestion that a raised element such as a ridge or an object such as an arm under the body could cause a local application of force. Dr Rieger said that firstly there was the fractured arm and secondly there was bruising to the abdominal wall which was localised. There were specific injuries to the mesentery and to the small bowel all of which fitted with a crush injury. Dr Rieger suggested that for a crush injury there was likely an object between the ground, the abdomen and the spine.

5.7. In cross-examination by Mr Bonig for Dr Pearton, Dr Rieger elaborated on his opinions by reference to the post mortem photographs. He pointed out a number of features including a mesenteric bruise consistent with a crush impact against an object or the ground against the spine. There were other features including fibrinous exudates on the linings of the small bowel at various sites where peritoneal leakage of intestinal content had occurred and where an inflammatory action had taken place. There was also redness on the lining of the bowel and the fibrin on top of it. Thus said Dr Rieger '*this is not a recent perforation, this has been going on for some time*'[33].

5.8. Also in cross-examination Dr Rieger questioned the absence of intramural haematoma as indicated by Dr Langlois. To Dr Rieger this did not suggest that there was a haematoma that had subsequently broken down[34]. Dr Rieger also pointed out that while Dr Langlois was suggesting that certain things could have happened, it was a question as to whether things <u>did</u> happen in that fashion. Dr Rieger was unshaken as to his belief that the perforation had occurred at the time of the accident. Dr Rieger reiterated in cross-examination that the perforation in the post mortem photography was typically how a perforation would look as a result of blunt trauma. He likened the intestine to a balloon type structure which if squashed will burst at its weakest point. Thus, in his view, there had been a compressive force which had burst the intestine. The compression against the vertebra had accounted for that. He said '*it*'*s just gone pop at the anti-mesenteric side*'[35]. He also likened the injury to a surgical incision in the small bowel that will pout[36].

5.9. Dr Rieger rejected a number of scenarios that may have suggested that the injury having been an evolving one over time. He dealt with the suggestion that even if the

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[33] Transcript, page 511
[34] Transcript, page 514
[35] Transcript, page 515
[36] Transcript, page 515

perforation had occurred at the time of the impact, the perforation may have been overlaid by another portion of bowel that had placed a lid, as it were, on the injury thereby delaying the onset of peritonitis. To this Dr Rieger stated that if from time to time a perforation was overlaid by portions of the bowel it would not have the potential to slow the rate at which peritonitis might develop. He said it is a free perforation, so the intestinal content will just leak into the abdominal cavity depending on what is in the intestine and what Leila had to eat or drink prior to the injury. He said '*I don't think there would be any aspect of intermittent leakage or cessation of leakage related to other nearby structures*'[37].

5.10. As to Dr Man's finding on the first occasion she saw Leila that Leila's abdomen was soft, Dr Rieger pointed out that Dr Man nevertheless found the abdomen to be tender which was still of significance. In any event, as had been seen, the child's abdomen was rigid by the time she arrived at the WCH. The other factor of course is that on her own version of events Dr Man had difficulty assessing Leila because of Leila's propensity to vomit when lying down.

5.11. As to the suggestion that Leila's presentation and observations might have been explained by bruising to the abdominal wall, Dr Rieger rejected this. He suggested that this would not cause a temperature or a high pulse rate. He said that if the person was distressed with pain there might be subtly high pulse rate, perhaps in the order of 110 or 120, but not at 146 together with a respiratory rate which he regarded as very fast and rapid breathing. He said it did not fit with simple bruising[38].

5.12. Dr Rieger was asked about the significance of the jump test. Dr Rieger was familiar with the test and suggested that with the inflammation, rawness and infection that might be caused by peritonitis a sudden jolt to the peritoneal linings will elicit pain[39]. So if the person cannot jump or in doing so the activity creates pain, then the suggestion is that they have a peritoneal irritation. Dr Rieger said:

> 'How come Leila can do it and yet she's got a gut perforation and she's got what we would then assume at this point in time is peritonitis related to it, yeah, it doesn't fit I agree with that. I mean I think this child – well I think she's very determined and will do things she's asked to do and she did it. Now, whether she grimaced in pain at the time, I don't know, you'd have to be there to watch it but I mean I think she probably would do it despite how sore her tummy was. That's how I interpret it and I don't know, that's a very subjective

[37] Transcript, page 526
[38] Transcript, page 460
[39] Transcript, page 469

> opinion of how I look at it and why that could occur. It's probably the only explanation I can give.'

5.13. Leila's performance in the jump test did not shake Dr Rieger's opinion that Leila had experienced the bowel perforation at the time of the swing accident. He maintained that opinion during the course of his evidence, based upon the nature of the perforation and the timing of Leila's death since the inflection of the original impact.

5.14. Dr John Raftos, the independent emergency physician, in his evidence wholly rejected the theory that Leila's bowel perforation may have occurred after Leila left the hospital. He said that he had no doubt that the perforation occurred at the time of the fall[40] and that a CT scan of the abdomen performed while Leila was in hospital would have revealed evidence of the injury. He said that he was absolutely definite about that[41]. He said that a CT scan would have shown evidence of gas outside the bowel. He based that opinion on his experience of these types of injuries. He said that it was known that Leila had perforated her bowel in the accident, that it was a common injury in children especially with bicycle handlebar injuries. He said '*I have not seen a case where there wasn't evidence on CT scan at the first presentation of the perforation*'[42]. He added that a CT scan within the first 6 hours of these injuries invariably leads to the diagnosis such that if she had been seen at the WCH and had a CT scan 12 hours after the fall it would have detected evidence of perforation[43]. Associate Professor Raftos also told the Court that what probably would have happened in Leila's circumstances is that the bowel content would have leaked out gradually from the perforation in the small bowel and that this would have caused a peritonitis that would have worsened progressively over several days[44].

5.15. Associate Professor Raftos virtually scoffed at the notion that Leila's jump test had any particular significance. He said that it was a '*great test*'[45] if it is positive but that if it is negative it means '*absolutely nothing*'[46]. Associate Professor Raftos said that the jump test was a test used to determine whether there was irritation of the peritoneum and like any physical examination test its sensitivity is poor, '*so of 100 children who have peritoneal irritation, for whatever reason, maybe 50-80 percent will have a positive*

[40] Transcript, page 1134
[41] Transcript, page 1134
[42] Transcript, page 1136
[43] Transcript, page 1136
[44] Transcript, page 1142
[45] Transcript, page 1144
[46] Transcript, page 1144

jump test and the corollary of that is that if you've got a positive jump test, then that's great you don't have to do anything more, but if you've got a negative jump test, it doesn't mean anything. It means that the child has still got a 20-30 percent chance of having the condition you're looking for.' [47]

5.16. In cross-examination by Mr Keane and Mr Bonig, Associate Professor Raftos accepted the proposition that it was possible for a person to injure the bowel and for the perforation not to occur on impact which is the scenario that Dr Langlois posited. Associate Professor Raftos said that the scenario was possible but that in his broad experience of these types of injuries in children he had never seen that happen. The perforation had always been obvious initially. In addition, when he has seen patients of this type at two, four or six hours since the injury, the CT scan has always shown evidence of perforation. He agreed, as Dr Langlois suggested, that an initial injury with subsequent breakdown and perforation was a possible scenario, but in this case it did not correlate with the clinical features of tachycardia on presentation, with fever on presentation, which he suggests is an indication of peritoneal irritation, and the rigid abdomen. He suggested that the rigidity could become soft even if there was peritonitis due to analgesia[48].

5.17. In the course of the Inquest other opinions were expressed in respect of the issue of the timing of the perforation. Dr McMellon and Dr Pearton concluded, and Dr McMellon noted at the time, that there were no signs of peritonism. It is fair to say I think that Dr McMellon's views were very much influenced by Dr Pearton's assessment. To my mind Dr Pearton's assessment was flawed for a number of reasons elsewhere identified, namely her erroneous beliefs about the circumstances of the fall and secondly the fact that there were no observations taken at the time and thirdly that Leila's original presentation and history was not properly taken into consideration.

5.18. Dr Craven, the Paediatrician and Emergency Physician who had at one point supervised Dr Pearton at the Flinders Medical Centre, asserted in his evidence that injuries to internal organs relating to playground equipment events would be incredibly uncommon to the point of being virtually unheard of[49]. He stated that children who present with an abdominal injury or potential abdominal injury have a history of landing

[47] Transcript, page 1124
[48] Transcript, page 1159
[49] Transcript, page 708

on an object or of having an object intrude into their body such as the handlebars of a scooter or bike. In his experience he had never encountered or heard of a paediatric patient who had a swing or playground misadventure and who had suffered a perforated bowel. I am not certain what the materiality of these observations was when it is known that Leila did suffer an internal abdominal injury except to the extent that its relatively uncommon nature might have wrong footed the clinician's at the WCH. However, the point needs to be made that Leila did have the arm injury and the possibility that this may have contributed to the internal abdominal injury was a matter that needed to be taken into account along with Leila's presentation generally when considering whether or not there was a possibility that she had suffered an internal abdominal injury. Dr Craven himself said that the theory that Leila possibly landed on her hand or arm which was driven into her belly and caused the necessary compression force that damaged the bowel was '*absolutely plausible*'[50] and that it was the most likely cause of the injury. He cryptically added that this was speculation notwithstanding his agreement that it was the most likely cause of the injury. Dr Craven's opinions that Leila did not exhibit signs of peritonitis at the time of her presentation at the WCH was based for the most part on an analysis of her signs and symptoms which other experts regarded as signs and symptoms of peritonitis.

5.19. As to the question of the existence of a perforation or not at the time of Leila's presentation at the WCH, Dr Craven seemed to suggest that this was an issue that was not the real question. He suggested that the real question was whether Leila had signs of peritonitis at the time she presented[51]. In the event I did not understand Dr Craven to be suggesting that Leila did not have a bowel perforation at the time of her presentation at the WCH, but rather than her overall condition did not speak of the possibility of peritonitis.

5.20. In the final analysis I have preferred the evidence of Dr Rieger on the issue as to whether Leila had a bowel perforation at the time of her attendance at the WCH. Dr Rieger is a clinician and a surgeon and his opinion that the appearance of the injury was more in keeping with a bursting type perforation rather than one that had resulted from a breakdown of tissue is a convincing opinion. Furthermore, I prefer Dr Rieger's views about the timeframe over which Leila's fatal condition developed, namely that it

[50] Transcript, page 710
[51] Transcript, page 714

was more in keeping with a peritonism over an extended period of time. To my mind Dr Rieger's evidence is to be preferred to that of the pathologist Dr Langlois insofar as there is any material difference in their approach. I have also preferred Dr Rieger to the evidence of any other clinician who has voiced an opinion to the contrary in respect of the issue as to whether or not Leila had a perforation at the time of her attendance at the WCH.

5.21. I have found that Leila suffered the bowel perforation at the time of the fall. I also find that the signs and symptoms that she displayed at the WCH were those of peritonitis.

6. Radiological and other imaging modalities

6.1. Leila underwent chest, abdomen and wrist x-rays at the WCH. The only abnormality revealed was the wrist injury. In issue in this Inquest was the utility of x-rays in the diagnosis of intra-abdominal injury. As well, there was considerable debate as to whether or not the appropriate modality of imaging should have consisted of either an ultrasound or a CT scan or both.

6.2. Evidence in respect of this topic was given by Dr Ruben Sebben who is a Radiologist and an interventional consultant. Dr Sebben obtained his original medical degrees from the University of Adelaide in 1979. He has been a Fellow of the Royal Australian and New Zealand College of Radiologists since 1987. From January 1995 to the present day, he has been engaged in private radiology practice at Dr Jones & Partners. He is also a Senior Visiting Medical Officer at The Queen Elizabeth Hospital and is also a Chief of Interventional Radiology at that hospital.

6.3. Dr Sebben provided a report[52] and gave oral evidence at the Inquest.

6.4. Dr Sebben gave evidence about the utility of x-rays, ultrasounds and CT scans in the diagnosis of intra-abdominal trauma. He also viewed the x-rays taken of Leila at the WCH. In his report he indicated that he agreed that the x-rays of the wrist, of the chest and of the abdomen have all been reported accurately. In particular, the x-ray reports of the abdomen and chest, insofar as they identify no abnormality, are accurate. I find that Drs McMellon and Pearton correctly interpreted the x-rays on the night in question.

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[52] Exhibit C23

6.5. In his report Dr Sebben asserts that a test by means of an abdominal x-ray is a test which is completely reliant on the presence of free gas where there is a perforation of a hollow organ such as the stomach, small or large bowel. Dr Sebben states that in up to 50% of cases a plain x-ray series may miss the presence of free gas which is the principal indicator of perforation of the small bowel. As such they possess no value in excluding this diagnosis. He asserts that in any case where perforation is a clinical possibility x-rays alone are insufficient for exclusion. The evidence from all sources at Inquest was unanimous in that x-rays may miss the presence of free gas in the abdomen in a significant number of cases. Varying percentages were mentioned. To my mind the exact percentage is immaterial. The salient point is that one could not exclude the existence of a perforation of a hollow organ by means of x-rays alone. Dr Sebben said that the rate of detection is unacceptably low for it to be used as a sole test for a perforation. Dr Sebben explained why this is so. He said its utility might depend on the volume of air which is entrapped around the site of the perforation. Very small volumes of air will not be visible. As well, it is not invariable that someone with a perforated bowel will have free gas. It may be a much more delayed finding. An x-ray of the chest and abdomen would also not reliably exclude damage to any other solid organ such as the liver or spleen.

6.6. All of the above naturally begs the question why a clinician would even bother undertaking a plain x-ray of the abdomen and chest where there is concern that a patient may have suffered an intra-abdominal injury. Dr Sebben himself suggested that there are experts in the field who would actually advocate not performing x-rays in these circumstances. He said that the x-ray sensitivity, specificity and accuracy are all so low that there may not be justification for performing an abdominal x-ray in this day and age especially where available alternatives provide a greater degree of accuracy, '*the issue being that if its negative you have no comfort at all that you have excluded an injury*'[53]. On the other hand, Dr Sebben suggested that x-rays would be appropriate in cases where there might be suspected pelvic or spinal fractures following, say, a high speed motor vehicle accident. However, if a person presented with a plausible history suggesting that there is an intra-abdominal injury, and one wanted to perform the definitive examination, then one would perform a CT scan. He said '*there is absolutely no doubt that the definitive examination for the diagnosis of or the exclusion of*

[53] Transcript page 570, line 24-26

significant intra-abdominal injury is a CT scan'[54]. CT scanning is considered to be the gold standard for the evaluation of abdominal trauma. In fact Dr Sebben's report asserts that when images are manipulated appropriately, CT is almost 100% accurate for the detection of free gas in the peritoneal cavity. It also allows accurate detection and quantification of injury to both solid and hollow organs. In the case of children, Dr Sebben asserts that while free air may only be present in 50% of children with bowel rupture, the secondary signs of bowel injury such as free fluid, abnormal bowel wall enhancement, thickened bowel wall, bowel wall discontinuity and mesenteric haematoma and infiltration are demonstrated by CT.

6.7. Dr Sebben acknowledged that no test is perfect and that there have been cases where a CT scan has been negative in the presence of a bowel perforation. He suggested that there is always the possibility of interpretive error and that on occasions an injury to the bowel may not be entirely obvious particularly in its early stages. However, generally with the passage of time such an injury will unmask itself because it will leak fluid and leak air and will induce an inflammatory reaction in the abdomen which becomes progressively more obvious[55].

6.8. In his oral evidence Dr Sebben dealt with the customary objection that is raised in relation to CT scanning, namely the unnecessary subjection of the patient to radiation. In his report Dr Sebben acknowledged that adverse publicity in both medical literature and the popular press regarding the cancer risk of CT examinations has resulted in greater hesitancy in ordering paediatric CT examinations even when clinically completely appropriate. In his oral evidence Dr Sebben alluded to the same difficulty but observes that as against this one would need to consider that there were ways to limit and control dosage of radiation through the way the apparatus is used[56]. He told the Court that modern scanners made within the last five years generally have quite effective radiation reduction strategies and that anything made in the last two to three years had '*very, very good radiation reduction strategies*'[57]. He points out that the equipment in the WCH would be state of the art in terms of dose reduction.

6.9. Dr Sebben states that performing a CT scan or not would depend upon the clinical situation in which there might be several options available. If the index of clinical

[54] Transcript page 571, line 26
[55] Transcript page 572
[56] Transcript page 599
[57] Transcript page 599, line 34

suspicion was high for an intra-abdominal injury, there would be reasonable justification for performing a CT scan and that can happen anywhere along the diagnostic pathway. On the other hand, if there is an element of uncertainty, a period of observation would be appropriate. If during that period of observation the symptoms did not abate, it would then be reasonable to consult whether a CT was appropriate. In fact Dr Sebben mentioned the utility of a period of observation more than once in his evidence. He said that '*a child with relatively mildly symptoms would probably benefit from a period of observation rather than from performing an immediate CT scan*'[58]. He added to this that one might miss some of the small bowel injuries with an early CT scan because they are inherently going to declare themselves later. It would therefore seem to the Court that what Dr Sebben is suggesting, namely a period of observation, would be an immensely sensible course for clinicians to follow in just about every case where a bowel rupture is suspected and not eliminated.

6.10. In his report Dr Sebben states that there are reasonable grounds for suggesting that in the case of Leila a CT examination may have shown evidence of bowel injury at the time of her WCH visit. In his oral evidence he was asked about Leila's clinical presentation and what it may have signified. While acknowledging that he had not practised clinical medicine for many years Dr Sebben stated that the rigid abdomen would have rung alarm bells with him, particularly in a child who was vomiting ten hours following an injury as Leila had, copiously, at the Strathalbyn Hospital. He would regard those two findings as highly significant in the presence of blunt abdominal trauma.

6.11. In commenting upon the radiologist's role in reporting on x-rays, and in particular assessing the clinical and other information that is made available, Dr Sebben suggested that a fall of between 2-3 metres for a relatively small child could be considered to be a height of significance. The reporting radiologist might possibly take that into account in what might be recommended by way of modality of imaging, which is part of the role of a radiologist[59]. Asked whether a radiologist might recommend a different suite of imaging than what the clinician has requested, Dr Sebben suggested that this happens frequently in the health system. He regards it as a radiologist's role to do that. Asked the obvious question as to how feasible that would have been at midnight, he said that

[58] Transcript page 596
[59] Transcript page 574

it might be reasonable to defer the discussion until the following morning and to see how the child is then[60]. Again, the question of delaying an imaging modality while a child is being observed during the course of the night would seem to be an eminently sensible approach.

6.12. Finally, Dr Sebben dealt with the issue of ultrasound examination. No ultrasound examination was performed in respect of Leila, although it will be remembered that Dr Man, the general practitioner, said that she believed an ultrasound had been performed. Dr Sebben explained the possible role of a type of ultrasound known as Focused Assessment with Sonography in Trauma, otherwise known as a FAST scan. In his report and in his oral evidence Dr Sebben explained that a FAST scan is an abbreviated mode of abdominal ultrasound. It is not undertaken in an attempt to actually identify specific organ injuries, but its main focus is to look for any evidence of free fluid such as blood or bowel contents in the peritoneal cavity. The machine can be used in an emergency department and not necessarily by a member of the radiology department. In his report Dr Sebben suggests that blunt abdominal trauma, particularly with the clinical symptoms exhibited in Leila's case, is considered an indication for performing a FAST scan. The detection of free fluid or blood would be an indication of significant intra-abdominal injury. Dr Sebben said that he was aware of the controversy regarding the use of FAST scanning and that there was a great deal of variation around the world in how it is used specifically in paediatrics. He said that although FAST cannot make a specific diagnosis, it has the advantage of being a completely non-invasive examination which probably takes less time to perform than moving a child to the radiology department. He said '*but its great power is in the detection of the presence of free fluid in the abdomen*'[61]. If there is 300ml of fluid in the abdomen or more, it will generally be seen on a FAST scan. However, if the result is negative, it would not rule out pathology[62]. The other advantage that Dr Sebben identified in relation to FAST is that during a period of observation one can perform as many FAST scans as the clinician desires, a consideration that is of great utility where a child deteriorates or the symptoms do not abate. In that scenario the machine can be used serially to detect whether there has been any change within the abdomen. It does

[60] Transcript page 576
[61] Transcript page 583, line 6-8
[62] Transcript page 583

not subject a child to radiation. Again, it would seem that such an approach could be aligned to a period of observation of the child.

6.13. It was said in some quarters during the course of the Inquest that a FAST scan is not indicated unless a child is haemodynamically unstable, an objection that was not really adequately explained. Dr Sebben countered that in the stable child there does not appear to be any limitations on the performing of FAST scan examinations. One can freely move to and from the child's bed with an ultrasound machine and use it intermittently over the course of a period of observation with no discomfort and minimal inconvenience to anybody.

6.14. In Leila's case, Dr Sebben said that although he did not know exactly when Leila's full blown perforation occurred, his understanding was that the hole in the bowel was quite significant in terms of size and that the only thing that he could go on was the fact that in his view the symptoms of peritonism were present quite early. For that reason he would have advocated a FAST scan or a series of FAST scans. He believes that twelve hours post injury there should have been some fluid visible. Asked as to whether the required 300ml of fluid may have been present when Leila presented, Dr Sebben stated that it could have been but added the rider that it would be difficult for him to say.

6.15. Dr Sebben added in cross-examination that he did not understand, and I would add here nor does the Court understand, why there is a reticence to perform a FAST scan in the paediatric population, although he acknowledged that there was such reticence. He said that there was a great deal of variation in this sphere, such that he had actually found one group in Israel that would take a negative FAST scan as being a very strong indicator in a large group of patients that there is no significant intra-abdominal injury. Dr Sebben acknowledged that the use of FAST scans is far more contentious in the paediatric population than in the adult population, but would point out that all that one is looking for it free fluid, which comment I took to mean that in essence there should be no difference in terms of its use in either population. It was put to Dr Sebben on behalf of Dr Pearton that Dr Pearton's view was that the literature does not support the use of FAST scan. To this Dr Sebben said that there was literature on both sides and one could '*selectively quote from whichever side one wanted to quote from*'[63]. Dr Craven would assert in his evidence that there is limited or no utility in the use of a

[63] Transcript page 603

FAST scan in children because it is highly unlikely that the required 300ml of blood would ever be detected in a child in the light of the relatively small blood volume that a child has. But the obvious riposte to this is that this case is not about the detection of blood loss but is all about the possible detection of bowel contents.

6.16. Dr Sebben produced to the Court a number of articles concerning various diagnostic modalities. Some of them related to the imaging of children with abdominal trauma. One article entitled 'Focussed Assessment with Sonography in Trauma (FAST)' [64], suggested within a list of the benefits of FAST examination that it is safe in pregnant patients and children as it requires less radiation than CT. Clearly the authors of this article contemplated the use of FAST in children. In another article entitled 'Paediatric Abdominal Trauma Workup'[65], it is stated under the heading 'Ultrasonography' that in the paediatric population the role of FAST is still unclear. It does go on to say that FAST is highly sensitive for the detection of free intra-peritoneal fluid. The article points out that because management protocols for solid organ injury in the paediatric population is highly dependent on accurate grading of the organ injury FAST currently cannot replace CT. The point that Dr Sebben was making, however, was that its utility is not in the identification of a solid organ injury, but in the presence of free fluid. There was no evidence adduced before this Court to suggest that this was any less a consideration in paediatrics than in adult medicine. The article also mentioned the possibility of false negatives but as Dr Sebben pointed out, the FAST scan can be used serially over a period of observation.

6.17. I found the suggestion that FAST is of limited or no utility in the detection of liquid bowel contents within the abdomen of a child to be quite unconvincing. On this issue I have preferred the radiologist Dr Sebben's evidence to all other evidence to the contrary.

6.18. One of the principal thrusts of Dr Sebben's evidence was that the imaging modalities that might be considered in a given case could well depend on the child being kept for a period of observation. The difficulty in Leila's case was that she was denied any such period of observation and so serial FAST scans, or even ultimately a CT scan, were not even under consideration.

[64] Exhibit C23e
[65] Exhibit C23f

6.19. In considering the utility of a FAST scan in Leila's case, it would need to be emphasised that it is not a diagnostic measure in and of itself. The literature that has been referred to insofar as it queries the role of FAST in a paediatric population does not appear to suggest that its sensitivity for the detection of free intra-peritoneal fluid is any different in the child from the adult. The existence of the free fluid is not necessarily diagnostic because the ultrasound does not identify any particularly injury. However, as Dr Sebben pointed out, it is a means to detect one abnormality that might ultimately lead to a definitive diagnosis of an injury.

6.20. In short, I do not understand why a FAST scan could not have been considered and administered in Leila's case.

7. <u>Leila is seen at the Strathalbyn Hospital</u>

7.1. According to Mrs Harkin's second statement[66] she and Leila arrived home from OSHC at about 3:35pm. I have already referred to the fact that Leila had complained of stomach pain and had vomited on at least two occasions. She also vomited on three occasions in the first hour after her arrival at home. She continued to complain of a sore stomach and looked pale. She lay on the couch dozing. Mrs Harkin decided to take Leila to the Strathalbyn Hospital as soon as her husband arrived home. Mr Harkin arrived home later than evening. Leila was taken to the hospital at about 10:00pm. She was seen by nursing staff in the first instance. Leila's vital signs included a temperature of 37 degrees, a pulse of 130, a respiration rate of 18 and a systolic blood pressure of 121. When seen by nurse Ms Sharon Nobes, Leila vomited. Leila moved her hand in a circular motion over her abdomen and told Ms Nobes that it hurt all over. When Ms Nobes palpated Leila's abdomen she noticed that it was soft but tender but with generalised guarding. When Ms Nobes was given to understand that Leila had fallen from a height she was concerned that the vomiting and the pain may have been an indication of abdominal trauma. In her oral evidence Ms Nobes told the Court that Leila had indicated the height from which she had fallen by putting her hand up. She said that she had fallen onto her abdomen, onto her belly.

7.2. Dr Man was fetched by nursing staff at about 10:15pm. Leila vomited when seen by Dr Man. Dr Man noted the history of vomiting prior to her presentation as well as the vomiting during that presentation. Dr Man noted Leila's complaint of abdominal pain.

[66] Exhibit C1b

Dr Man explained that although she recorded that Leila's abdomen was soft and tender, Leila continued to vomit and for this reason Leila was not able to lie down long enough to enable Dr Man to conduct a detailed examination of her abdomen. In her oral evidence Dr Man told the Court that Leila could not relax her muscles enough for Dr Man to actually have an accurate feel. Dr Man became concerned about the possibility of splenic laceration or rupture of the bowel. As already indicated, Dr Man was most concerned by the height at which Leila was said to have fallen.

7.3. Dr Man attempted to provide anti-emetic relief by way of an ondansetron wafer. Leila had difficulty keeping the wafer under her tongue. Paracetamol was attempted to be administered but was not given due to Leila's persistent vomiting.

7.4. Dr Man phoned the WCH and spoke to a medical practitioner who indicated Leila would be assessed if she was brought into the WCH. It was decided that Leila would be driven by her parents instead of being transferred by ambulance as car transport would be quicker.

7.5. There can be no suggestion other than that Dr Man appropriately managed Leila at this point. She did not feel that she was in a position to accurately assess Leila. She was concerned naturally about the trauma that Leila had experienced and the fact that she was prevented from making a proper assessment due to Leila's inability to lie flat without vomiting. Dr Man correctly referred Leila to the WCH.

8. <u>Leila is conveyed to the WCH and is triaged</u>

8.1. The Strathalbyn Hospital patient attendance record states that Leila and her parents departed that hospital at 10:30pm. Dr Man confirms that Leila left the building in a wheelchair as she did not want to walk. Leila and her parents then made their way to the WCH, stopping briefly at their home to collect some warmer clothing. According to Mrs Harkin's statement Leila dozed in the back seat during the journey to the WCH.

8.2. Leila and her parents took Dr Man's written referral letter which made reference to Leila having jumped off a swing from a height of about 8-10 feet, that she had landed on her hands and abdomen and that she had since vomited 5-6 times of clear fluid. The letter also made reference to Dr Man's difficulty in examining Leila due to the fact that lying down exacerbated her vomiting. The letter was handwritten by Dr Man on SA Health letterhead.

8.3. At the WCH Mr and Mrs Harkin and Leila made their way to the emergency department. They walked slowly. Leila continued to clutch at her stomach as they walked. I would add here that Leila's ability to mobilise at various times at the WCH became something of an issue at the Inquest. At one point in the course of these proceedings, the possibility that CCTV imagery of Leila's presence in the WCH might still exist was raised by counsel. The Inquest was adjourned for the purpose of exploring that possibility. Unfortunately any CCTV footage no longer existed. I was satisfied that appropriate efforts had been made to locate the footage.

8.4. The WCH emergency department triage record indicates that Leila's presentation time was 11:40pm with a Priority code of 2. The typed part of this document[67] was completed by the triage nurse Ms Sanders to whom I have already referred. The fact that Leila had been referred by another doctor was recorded on this document. While I accept that Dr McMellon saw and read the letter of Dr Man, Dr Pearton would not see or read Dr Man's letter notwithstanding that it contained important information.

8.5. Ms Sanders was called to give oral evidence at the inquest. She had retired from nursing since Leila's death. She had worked as a registered nurse since 1976 and had worked at the WCH since 1993. She had worked in the emergency department of the hospital since 1996. Ms Sanders gave her evidence in December of 2015. She appeared to have a good recollection of Leila. Ms Sanders told the Court that she received and read Dr Man's letter[68]. She said that she came around the triage desk specifically to examine Leila. Ms Sanders told the Court that she listened to Leila's chest and determined that Leila was quite tachycardic. Her heartbeat was quite fast. In this assessment Ms Sanders made allowances for the fact that a child being examined in hospital is frequently anxious at first. However, she said that she repeated the assessment and Leila was still tachycardic. Although Ms Sanders did not make a specific note as to the heart rate, she told the Court that in her view the heart rate was in excess of 150 beats per minute which she would class, and would objectively be classed, as tachycardic. Although she did not take Leila's temperature, it would be taken by nurse Defrancesco shortly thereafter. I accepted Ms Sanders evidence that Leila was tachycardic with a heart rate of, if not in excess of, 150 beats per minute. It is a figure that corresponds with that recorded by Ms Defrancesco shortly thereafter.

[67] Exhibit C10, page 44
[68] Transcript, page 543

Ms Sanders told the Court that as far as Leila's respiratory rate was concerned she believed that Leila was in pain, was tachycardic and that her breaths were to be characterised as sighing as if Leila was worried, as distinct from her respirations being abnormally fast[69].

8.6. Ms Sanders told the Court that Leila was pale and that that her arm was sore. Ms Sanders suspected a fracture. She asked Leila for permission to touch her stomach and asked Leila to show her where it was sore. Leila indicated her lower abdominal area. When Ms Sanders felt her abdomen she described it as '*very rigid*'[70]. This discovery prompted Ms Sanders to call the Primary Assessment Team (PAT) so that a nurse would take Leila straight to the resuscitation area. What particularly concerned Ms Sanders about Leila was the rigidity of her abdomen. She said:

> 'I thought the mechanism of injury was because it was a blunt injury, it might have been, sort of, similar to a handlebar injury, and that could cause abdo trauma, and I was concerned about that.'

Indeed Ms Sanders told the Court that she had been very concerned about Leila to the point that her '*alarm bells were ringing about this child*'[71].

8.7. Ms Sanders told the Court that having called the PAT she had no further role in Leila's management and did not see her again. The PAT nurse was Ms Defrancesco to whom Ms Sanders explained the mechanism of Leila's injury as she believed it to be.

8.8. Ms Sanders was closely questioned by counsel and by myself about a question mark adjacent to the word 'RIGID' as recorded by Ms Sanders on the triage document. She explained to the Court that Leila did have a rigid abdomen but that she had not known the full reason for that except to the extent that it possibly reflected bleeding or blunt trauma[72]. So the question mark related to Ms Sanders' desire to know the reason for Leila's rigid abdomen. Ms Sanders rejected the suggestion that the question mark had reflected doubt in her mind about whether or not Leila did in fact have a rigid abdomen. She told the Court '*no, she did have a rigid abdomen*'[73]. Ms Sanders was also closely questioned as to whether she understood the distinction between a rigid abdomen on the one hand and on the other voluntary guarding which is a mechanism that a person

[69] Transcript, page 549
[70] Transcript, page 554
[71] Transcript, page 545
[72] Transcript, page 546
[73] Transcript, page 560

can consciously adopt to protect that person's abdomen from pain. She explained that voluntary guarding was a reflection of the fear of being touched, whereas involuntary guarding was a mechanism to protect the person. She believed that Leila was not voluntarily guarding. She said '*I didn't think Leila was doing that on her own, I think it was there*'[74].

8.9. I have carefully scrutinised Ms Sanders' evidence. I took into account the possibility that Ms Sanders may have wanted her actions regarding Leila to be seen as heroic, or that she may have wanted to have been regarded as the only person who accurately assessed Leila for what she had been, a very ill patient. I saw none of that in Ms Sanders' persona or from performance in the witness box. I accepted Ms Sanders' evidence that she believed that Leila displayed a rigid abdomen due to involuntary guarding. I also have accepted her evidence that Leila, at that point, did in fact display involuntary guarding and had a rigid abdomen.

8.10. Asked as to how Leila mobilised, Ms Sanders said that Leila had walked into the triage area and had appeared to be walking well. She did not know how Leila was taken to the resuscitation area, but it will be seen that Ms Defrancesco took her in a wheelchair.

8.11. An issue arose during the course of the Inquest as to whether or not having regard to certain aspects of Leila's presentation at that point in time, that is at triage, the Paediatric Trauma Team Activation Criteria for patients less than 16 years of age had been met. Ms Sanders was questioned about her knowledge of these criteria and whether in the circumstances she ought to have activated it. There are two Levels within the activation criteria, Level 1 and Level 2. There can be no question but that in this instance the Level 2 activation criteria had been met. There was evidence to suggest that Leila could well have fallen from a height exceeding 2 metres. To my mind clinical staff at the WCH could not have acted on any other basis. This of itself would have activated Level 2. What I am uncertain about is whether if this Level had been activated Leila's management would have been materially different. I note from the WCH Trauma Manual[75] that a Level 2 response in normal hours would consist of the activation of a team that would include a trauma consultant, but in the case of a person presenting at that time of night the team would be led by a paediatric registrar and paediatric nurses. Dr McMellon was a paediatric registrar and I infer that the nurses

[74] Transcript, page 561
[75] Exhibit C16a

who dealt with Leila were paediatric nurses. I was not persuaded that the strict application of the Level 2 activation criteria would have made any material difference to the nature of Leila's management. The better question was whether a Level 1 response should have occurred, and whether that would have made any difference, matters that I will deal with in another section of these findings.

9. Leila is seen by Registered Nurse Defrancesco and Dr McMellon

9.1. To set the scene for what occurred here it is worthy of note that Leila had been ill throughout the day since her fall. When seen by Dr Man at Strathalbyn at 10:15pm she was still manifestly ill. She was the same, if not worse, although not vomiting, on Leila's arrival at the WCH at 11:40pm. Dr McMellon saw her at 11:50pm, only ten minutes later. She would be x-rayed at 12:03am. There was a divergence in the descriptions of Leila's condition in that time frame notwithstanding its short duration, and by 1am she was said to be clinically unremarkable. The variation in descriptions was difficult to align with ordinary human experience. More of that later.

9.2. Both Ms Defrancesco and Dr McMellon gave evidence at the Inquest on two separate occasions. The first occasion for both occurred in December 2015.

9.3. Ms Nicole Defrancesco has been a registered nurse since approximately 2002. She has worked at the WCH since that time. She has worked in the emergency department and other departments within the hospital. On the night in question she was working in the emergency department. Ms Defrancesco explained that on this particular shift there are a number of nurses on duty including a coordinator, three resuscitation nurses and four room nurses in the main area. There are also two nurses in the extended short stay area. There is also the triage nurse and a triage assist. During this shift Ms Defrancesco was one of the resuscitation nurses. As such her duties were to support the room nurses and to provide general assistance to other nurses and doctors in the department. Ms Defrancesco correctly recalled that Ms Ingrid Sanders was the triage nurse that night.

9.4. Ms Defrancesco told the Court that a 'Priority 2' was called within the department through the loud speaker system. This meant that Ms Defrancesco was required to attend the triage area to collect a patient. The patient in this instance was Leila. Ms Sanders gave Ms Defrancesco a brief handover and suggested that the information was that Leila had jumped off a swing, had landed on her abdomen and hands.

Ms Sanders told Ms Defrancesco that '*she might have a rigid abdomen*' and she looked pale and uncomfortable.

9.5. Ms Defrancesco met Leila and observed for herself that Leila appeared to be uncomfortable and in pain. As a result of those observations Ms Defrancesco obtained a wheelchair and wheeled Leila to cubicle 1. Leila was accompanied by her mother. At cubicle 1 Leila was asked to climb onto a barouche. Ms Defrancesco told the Court that she believed that Leila had required some assistance in order to do that because she was uncomfortable and in pain. Dr McMellon arrived at the cubicle shortly thereafter. Prior to her arrival, Ms Defrancesco took some vital sign observations of Leila and also completed a nursing assessment document[76]. The assessment document has a time of 2345 hours applied to it by Ms Defrancesco. I have already referred to some of the document's notations concerning the circumstances of Leila's fall. In addition to those notations Ms Defrancesco noted that Leila was self-ventilating but with increased work of breathing which she noted as being pain related. Ms Defrancesco told the Court that she wrote this because Leila looked like she was in pain, had indicated herself that she was in pain and that sometimes pain can result in a patient's observations being elevated. She also wrote that Leila was pale and tachycardic with a dry coated tongue. In addition Ms Defrancesco recorded that Leila was alert but flat, meaning that she was '*not overtly active or spritely*'[77]. Ms Defrancesco also noted that Leila had possibly already taken a tablet for nausea. I take it that this was meant to be a reference to the ondansetron wafer that Leila had difficulty with at Strathalbyn. As far as the recording of Leila's vital sign observations were concerned, as entered on the observation chart itself, Ms Defrancesco noted that the time of the taking of observations was 2350 hours which must have been very shortly before Dr McMellon entered the cubicle. She noted that Leila had a temperature of 38C degrees which is elevated (febrile) and in keeping with illness, that she had a pulse of 146 which is also elevated (tachycardic), that she had a respiratory rate of 36 which is elevated, a systolic blood pressure of 119 which Ms Defrancesco regarded as slightly elevated and a pain score of 7 out of 10 which is significant. These figures were entered onto the chart by Ms Defrancesco. The only figure that was replicated within the nursing assessment document was the temperature. In this regard Ms Defrancesco wrote '*Temp 38*'.

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[76] Exhibit C10, page 50 & page 48 respectively
[77] Transcript, page 57

9.6. The figure of 38 as written by Ms Defrancesco on the observation chart would be the subject of important evidence at the Inquest. Both Dr McMellon and Dr Pearton would tell the Court that, independently of each other, they both misread Ms Defrancesco's figure of 38 as being 36 which would signify a normal temperature, not the febrile temperature of 38. Of course, Ms Defrancesco had intended to signify that Leila had a temperature. She wrote the figure on the documentation in two places. It is worthwhile observing that three of Ms Defrancesco's observation parameters have the figure 6 in them, namely the pulse of 146, the respiratory rate of 36 and motor response of 6. Those figures are all immediately adjacent to the figure she recorded on the observation chart for Leila's temperature. It is fair to say that the figure of 8 in the recorded number of 38 for Leila's temperature, even if at first blush it appears as ambiguous, is nothing like Ms Defrancesco's figures of 6. Furthermore, the figure as recorded on the nursing assessment document is unmistakeably 38. For my part it is difficult to say that Defrancesco's figure of 8 as it appears on the observation chart manifestly resembles a 6 such that a person reading it would unhesitatingly read it as a 6. Any uncertainty or ambiguity in respect of the figure as it appeared on the observation chart could have been easily clarified by comparing it to Defrancesco's other 6s or by reading the clearer figure of 38 as it appeared on the nursing assessment document, both of which form part of the same conjoined four page sheet. Alternately, or in addition if doubt still remained, Dr McMellon could easily have asked Ms Defrancesco to clarify the matter. Defrancesco was right there. She had written all of the figures only a matter of a few moments before. I have no doubt that if either Dr McMellon or Dr Pearton had properly read the entirety of this document they would have reached a conclusion that Leila had presented with a raised temperature, a temperature that along with other symptomatology and with her history would inevitably have raised a question as to whether Leila was suffering from inflammation or infection that, say, had been sustained by way of a traumatic ruptured bowel. And as will be seen, it would also have raised a serious question as to whether a Level 1 trauma response would have been called for, carrying as it does the need for surgical review which Leila would never have the benefit of.

9.7. As to the departure from normality that these observation figures represented I will deal with that in due course. In any event, it is a matter of certainty that Leila's temperature was never taken again at the WCH. This was said, at least in part, to be due to the erroneous belief that at no stage had Leila been febrile at the WCH. It is also true that

no further record was made of any further set of observations that included measurement of pulse or respiratory rate. Indeed, as was acknowledged to have been contrary to required practice, no hourly set of observations was made in respect of Leila. This should have routinely occurred and have been administered by nursing staff at approximately 12:50am, an hour since Ms Defrancesco's first set of observations. I observe here that the hourly requirement is clearly stipulated on the front sheet of the nursing assessment document. The box in the bottom left hand corner states that baseline observations are required for all patients, which in Leila's case did occur, and that observations were required '*hourly thereafter unless clinically indicated*', which did not occur. There is no suggestion that a set of observations timed at 12:50am would not have been 'clinically indicated'. On the contrary, they would certainly have been clinically indicated having regard to the abnormalities identified in the set of observations taken at 11:50pm. The only set of formal vital sign observations that were claimed to have been taken since Ms Defrancesco's set were purportedly taken by Dr Pearton prior to Leila's discharge. Neither Dr Pearton nor Dr McMellon made a note of any such observations. Although Dr Pearton would claim in her own evidence that she told Dr McMellon that Leila's observations were normal, a matter that Dr McMellon did not record or recall, she failed to advise either Dr McMellon or Leila's parents of the measurements even though those persons were all present when Dr Pearton said they were taken. The only record that was ever made in respect of those observations was that contained in the ex post facto progress note that Dr Pearton compiled after Leila's death. The nature of those observations I shall deal with in due course. For the time being I intend to concentrate on what occurred when Dr McMellon examined Leila for the first time at 11:50pm.

9.8. I should add here that Ms Defrancesco told the Court that she had a recollection that after Leila had been to the x-ray suite, she observed Leila in cubicle 1 and that Leila was connected to the observations monitor. Ms Defrancesco told the Court that she remembered that at a later stage that evening, she could not recall when, that Leila's readings *'seemed to be more of a normal reading, especially her heart rate'*. Ms Defrancesco did not make any note or record of any such readings and she did not lay claim to having drawn anything of the kind to anyone else's attention. No other person who had anything to do with Leila claimed to have made the same observation as Ms Defrancesco.

9.9. Dr Amy McMellon described herself to the Court as a paediatric trainee. She completed her original medical degree in 2011. She completed her internship at the Queen Elizabeth Hospital in 2012 and commenced her paediatric traineeship in 2013. At the time of these events Dr McMellon was in training to become a paediatrician in general medicine. On the occasion in question Dr McMellon was on a night shift, starting at 10:15pm and finishing at 8:15am. Dr McMellon was the registrar for the whole shift. As I understood her evidence, there was also a resident medical officer lower in rank and experience than her also working. Above her was the Fellow, Dr Pearton, and Dr Smith the Consultant.

9.10. Ms Defrancesco performed a brief handover with Dr McMellon and then left the cubicle. Ms Defrancesco had already taken the observations to which I have referred. She could not recall whether she had specifically mentioned to Dr McMellon that she had recorded Leila's temperature as being 38. She did not remain while Dr McMellon examined Leila. Dr McMellon has not written on the nursing assessment document nor on the observation chart. In the first instance Dr McMellon used the triage assessment document to write on and then used different blank lined pages to record her examination. Dr McMellon copied onto that document some of the figures from the observation chart, namely the heart rate of 146, the respiratory rate of 36 and the blood pressure of 119. It is therefore clear that she at least saw those of Defrancesco's figures that had a clearly legible 6 in them. She did not herself note a figure for the temperature that had been taken by Ms Defrancesco. She simply wrote the word '*Afebrile*' in her note. Afebrile means that the temperature does not exceed normal. Dr McMellon told the Court that the conclusion of afebrility had been drawn from her erroneous reading of the figure of 38 as recorded on the observation chart. From an objective standpoint the description of afebrile would also be consistent with Dr McMellon misinterpreting a correctly read figure of 38. My inclination is to accept Dr McMellon's evidence that she misread the figure as distinct from having misinterpreted it, simply on the basis that no reasonable paediatric registrar could regard a temperature of 38 as afebrile. Either way, the error is unforgiveable. On the assumption that Dr Pearton came to the same misunderstanding, that too is unforgiveable.

9.11. I have already dealt with Dr McMellon's notation concerning her understanding of the circumstances of Leila's fall. As to Dr McMellon's clinical observations of Leila, she initially wrote in respect of Leila's abdomen '*rigid and unable to palpate without*

indicating pain'. This of course would be consistent with the typewritten note on the same triage document as inserted by Ms Sanders.

9.12. Dr McMellon told the Court that when she first saw Leila she was being brought around from the triage desk to the first cubicle and was the final few metres from that cubicle. She said that at that point Leila was walking with her mother. She told the Court in her examination-in-chief that she was sure that Leila was walking. She said that there were two nurses with her as well. Dr McMellon also said that she watched Leila get up onto the bed. She said that Leila appeared to do this easily and that she did not look like she was having any trouble or experiencing any pain in doing so. It will be remembered, however, that Ms Defrancesco told the Court that Leila looked pale and uncomfortable and for that reason she took Leila to the cubicle in a wheelchair. She was supported in this by a nurse Ms Basford whose evidence I shall mention in due course. Ms Defrancesco also said that Leila needed assistance to get onto the barouche as she was uncomfortable and in pain. Although Ms Defrancesco knew from the triage nurse, Ms Sanders, that Ms Sanders thought that Leila might have had a rigid abdomen, she did not make any observation of her own about whether Leila had a rigid abdomen because it was too hard to assess her abdomen as Leila was in a lot of pain and that in any event Dr McMellon arrived soon after she had conducted her initial assessment[78].

9.13. I have preferred the evidence of Ms Defrancesco to that of Dr McMellon in relation to the manner in which Leila climbed onto the barouche in cubicle 1. Leila was the focus of Ms Defrancesco's attention at that time. She knew that Leila was experiencing significant pain and for that reason would have been more alert than Dr McMellon to Leila's ability or otherwise to ascend the barouche. I also find that Leila was taken to cubicle 1 in a wheelchair due to Ms Defrancesco's observation that Leila was in discomfort.

9.14. As to Dr McMellon's notation that Leila's abdomen was rigid, in her evidence Dr McMellon stated that she had not been able to palpate anywhere on Leila's abdomen without her indicating pain. However, she told the Court that she had thought that part of the rigidity was due to voluntary guarding. Against her notation about rigidity Dr McMellon has entered in brackets '*(?voluntary guarding)*'. By this Dr McMellon had used the word voluntary in the sense that Leila had possibly tensed her muscles not

[78] Transcript, page 773

because of an underlying problem within the bowel, but because the muscles were tender when pushed on[79]. At other times the muscles would be relaxed. Dr McMellon told the Court that rigidity can be a sign of peritonism, and that one would be concerned that there were underlying problems within the abdomen. In particular, one would be concerned that there might be a perforation. According to Dr McMellon, other observations that were relevant to that potential diagnosis were the fact that Leila's heart rate was to use her words '*mildly up*', and that her respiratory rate was mildly up, which indicated that she was in some pain. On the basis that Leila's temperature was actually 38 and not 36 as Dr McMellon had believed it to be, she was asked this question:

> 'Q. If you take the temperature, the heart rate, the respiration together with the potential for a rigid abdomen, what suspicions might you have.
>
> A. That she might have had a perforation. '

Questioned as to the facet of Leila's presentation that most significantly might give rise to suspicion of a perforation, Dr McMellon suggested that it would be rigidity of the abdomen[80]. Questioned as to the significance of Leila's vomiting, Dr McMellon acknowledged that it could be a sign of inflammation in the abdomen, possibly due to peritonitis. Alternatively, it might reflect an obstruction within the abdomen. As well, it could be consistent with abdominal pain.

9.15. Dr McMellon also detected the fact that Leila may have had an injury to her arm. Given the history that she had received, Dr McMellon formed the view that she needed to have Leila's arm x-rayed. She added, '*her chest sounded clear but her abdomen when I laid her down she tensed up all the muscles and so I thought well, I need to do an x-ray to look for signs of a perforation*'[81]. The purpose of the x-rays in Dr McMellon's mind was to look for free gas under the diaphragm which would be an indication of a bowel perforation. There was a deal of evidence given during the course of the Inquest about the efficiency of such a diagnostic modality and whether or not the absence of free gas on x-ray was of diagnostic significance. I will deal with that issue later in these findings, as well as the issue as to whether or not CT scans or ultrasound would have been a more appropriate diagnostic modality in the circumstances of this case. Suffice

[79] Transcript, page 114
[80] Transcript, page 117
[81] Transcript, page 99

it to say for the moment, an x-ray that is negative for free gas would not be of determinative diagnostic significance.

9.16. In cross-examination by counsel assisting, Ms Kereru, Dr McMellon stated that if she had understood that Leila's temperature was 38 degrees, not 36, she would have written '*low grade fever*' in her notes and not have described Leila as afebrile. Asked as to what she would have done if she had appreciated the correct temperature, Dr McMellon told the Court that she would still have sent Leila for x-rays but would have been more diligent in looking to make sure that her observations had normalised, especially the temperature. If they had conducted further observations and they had not in fact normalised she would have been more inclined to say that Leila should have stayed in hospital for the night. It is a matter of certainty that no further observation in respect of Leila's temperature was taken. Asked as to what may have occurred if another high temperature had been observed before discharge, and the pulse and respiratory rates had remained high, Dr McMellon suggested that they would have obtained a surgical review and '*at minimum stay the night*'[82]. Dr McMellon said that if this had occurred, Leila's clinical picture would have been monitored. She would have been especially observed for further vomiting and pain. It is worthwhile noting here that following her discharge from the WCH, it is said by Mr Harkin that Leila vomited in the car on the way home. As well, it is clear that Leila started vomiting again first thing in the morning and thereafter showed continued signs of clinical unwellness. I have no doubt that all of this would have declared itself if Leila had been kept at the WCH and that as a result she would have been reassessed.

9.17. Prior to Leila going up to the x-ray suite Dr McMellon prescribed paracetamol for her pain. The medication chart[83] reveals that 400mg of paracetamol was provided to Leila at 11:57pm.

9.18. It is worth observing here that Dr McMellon's examination of Leila occurred within ten minutes of her arrival at the WCH, and approximately ten minutes after she was first triaged by Ms Sanders. There is no reason to suppose that Leila clinically presented in any different way at the time of Dr McMellon's examination from how she had presented to Ms Sanders and then in turn to Ms Defrancesco. I was persuaded by the evidence of Ms Sanders that Leila was experiencing abdominal rigidity that was due to

[82] Transcript, page 190
[83] Exhibit C10, page 52

involuntary guarding and I am also of the view that what Dr McMellon detected was the same thing, albeit that she was confronted with the recorded difficulty that she was unable to palpate Leila's abdomen without inviting pain. That would explain why Dr McMellon wrote her note '*(?voluntary guarding)*'. I am reinforced in the view that Leila was exhibiting involuntary guarding at the time she was seen by Dr McMellon by Dr McMellon's medical imaging request document[84] which included within the clinical details her reference to Leila having a rigid abdomen without any qualification about whether that was due to involuntary or voluntary guarding.

10. Leila is sent for X-rays

10.1. I have already made mention of the fact that the x-ray department closed at midnight. For that reason the clinicians attending to Leila were under pressure for time. It is reasonable to infer that Leila was taken to the x-ray department with all necessary haste. I note from the radiology report[85] that Leila was x-rayed at 12:03am. Accordingly, and taking into consideration the potential effect of paracetamol administered only six minutes prior to that, it is unlikely that Leila's presentation at the time of being taken up to the x-ray department, and while at that department, would have been materially different from what it had been in the 20 to 25 minutes since she was triaged.

10.2. Leila was taken to the x-ray department by a registered nurse, Chloe Basford. Ms Basford gave oral evidence at the Inquest. Like Dr Pearton, Ms Basford had created a retrospective note written on a WCH progress note which was produced for the first time during the course of the Inquest. Ms Basford was the nurse in charge of rooms 1 to 3 that included the cubicle in which Leila was examined. Ms Defrancesco was a resuscitation nurse who Ms Basford said was there to support her with her duties. Like Ms Defrancesco, Ms Basford heard the PAT nurse-to-triage call. From cubicle 2 Ms Basford observed Ms Defrancesco bringing Leila into cubicle 1. Ms Basford confirmed that Ms Defrancesco brought Leila into the cubicle in a wheelchair. Shortly thereafter Ms Basford received a handover from Ms Defrancesco. Dr McMellon had already entered the room. The doctor's assessment was then conducted. Ms Defrancesco told Ms Basford that the patient looked pale and was complaining of abdominal pain after falling from a swing earlier that day. Ms Basford was advised that Leila would need an x-ray so to this end Ms Basford telephoned the radiology

[84] Exhibit C10a
[85] Exhibit C10

department to advise them that they would be coming up and for them not to close at midnight. Ms Basford then took Leila up to the x-ray department on the barouche that Leila had already been place on in cubicle 1.

10.3. Following the x-rays Ms Basford accompanied Leila and her mother back to cubicle 1. The wrist x-ray revealed a fracture. Leila had a backslab applied to her wrist by Ms Basford and Ms Defrancesco. There is a dispute as to the location of the room in which the backslab was applied. Ms Defrancesco and Ms Basford both insist that this occurred in cubicle 1 to which Leila was returned after the x-rays, whereas Leila's parents assert that Leila was taken to another room which Mrs Harkin was able to describe in some detail by reference to its decoration. I am not certain what if anything turns on this dispute. Mrs Harkin asserts that Leila had difficulty moving from cubicle 1 to this room, the implication being that this would have provided an opportunity for the nursing staff to observe how ill Leila was. Given the insistence on the part of the nursing staff that Leila did not need to move from cubicle 1 it is difficult to know what to make of this dispute. I make no finding about this issue.

10.4. Ms Basford told the Court that in essence she would have been the person responsible for conducting further observations on an hourly basis. She did not. She told the Court that she intended to take a set of observations after Leila had been reviewed but that she did not have an opportunity to do so because Leila had been discharged.

10.5. Ms Basford was called to give evidence principally to deal with the issue about her clinical observations of Leila as to her appearance and the manner in which she ambulated. Ms Basford's handwritten ex post facto note records that when she first observed Leila she was grey in appearance and was complaining of nausea and pain to the wrist. She also wrote that Leila ambulated well between the barouche and the x-ray equipment and that she had placed both hands on the barouche and had '*jumped onto barouche*'. The note also records that after a '*full assessment*' had been conducted by the doctors Leila was able to jump and ambulate without assistance and that the colour had returned to her face.

10.6. In her oral evidence Ms Basford said that when Leila descended from the barouche she had to assist her as Leila's feet could not reach the floor. Leila did present with a little discomfort with her arm but otherwise presented quite well. Ms Basford said that at that point the colour was returning to her face and that she ambulated quite easily.

When asked as to whether Leila had exhibited pain she said that she did not. Ms Basford said that during the x-ray process Leila was slow but fine and did not complain of any pain[86]. There was some discomfort associated with the positions that Leila was required to put her wrist into. After the x-ray Leila '*popped both her arms on the barouche and jumped onto the barouche*'[87].

10.7. Ms Basford told the Court that after the x-rays Leila was taken back to cubicle 1 where she and Ms Defrancesco put the backslab on Leila's arm as required by the doctors. By this time it was about 12:30am. Following the application of the backslab Leila was then assessed by Drs McMellon and Pearton. Ms Basford did not remain while that took place.

10.8. In cross-examination by Ms O'Connor SC for Mr and Mrs Harkin, Ms Basford acknowledged that she only saw Leila take about nine steps[88]. She also acknowledged that Leila had stayed on the barouche for the purposes of the backslab being applied.

10.9. To my mind Ms Basford's evidence did not advance the resolution of the issue as to Leila's overall presentation. I have preferred Ms Defrancesco's and Ms Sanders' impressions of Leila's presentation. Ms Basford had limited opportunity to gauge Leila's ability to mobilise. It would be remarkable if in the space of approximately thirty minutes Leila's presentation had altered so significantly and without explanation other than the administration of paracetamol shortly before midnight. Ms Basford's evidence does not in any way diminish the notion that when Leila arrived at the emergency department of the WCH, and when seen shortly thereafter by two members of the nursing staff, she appeared to be in considerable pain and had a rigid abdomen.

10.10. Ms Basford's evidence in relation to the failure to take a further set of observations is another matter than I will return to in due course.

11. Leila is reviewed and discharged

11.1. This review was against the background that Dr McMellon did not think that she should send Leila home and that she was contemplating obtaining a surgical opinion having regard to the fact that in her assessment Leila was still experiencing pain in the central area of her abdomen. As well, the reason that she wanted Dr Pearton to see Leila was

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[86] Transcript, page 806
[87] Transcript, page 807
[88] Transcript, page 824

because she wanted to ask Dr Pearton whether she should in fact obtain the surgical opinion at that point. The decision to obtain that opinion was, in Dr McMellon's mind, dependent on Dr Pearton's review. According to Dr McMellon the review also took place against the background that to her knowledge there had not been another set of observations taken since the original set taken by the nursing staff shortly after Leila's presentation.

11.2. The accounts of what took place when Leila was reviewed for her discharge are markedly divergent. Aside from Leila herself, the other persons present at the review were her parents, Dr McMellon and Dr Pearton. The review was conducted by Dr Pearton. This was the only occasion on which Dr Pearton saw Leila.

11.3. Leila was discharged from the WCH at approximately 1:30am. There is a divergence in the evidence as to whether or not the application of the backslab took place before or after the review. When I speak of a divergence, in reality the only person who asserted that the backslab was applied after the review was Dr Pearton. Every other person who knew of the application of the backslab or was present when it took place asserts that it took place prior to Dr Pearton's review. The preponderance of evidence is that the application of the backslab occurred prior to the review and that Leila was discharged very soon after that review. I do not know how or why Dr Pearton would be at odds with the rest of the evidence. What can be said is that if Leila had the backslab already applied prior to the review, it may arguably have inhibited a proper assessment of some of her responses, including her ability to jump which as will be seen was a matter that Dr Pearton took into account in assessing Leila. On the other hand, if the backslab had been applied after the review it would have provided nursing staff with an opportunity to take further vital sign observations. For what it is worth I have found that the backslab was applied before the review.

11.4. The only clinical note concerning the review that was made on the night in question was made by Dr McMellon who was present for the review. That note is as follows:

> 'Addit: Pain improved.
> R/V with ED Fellow
> Abdo soft, nil signs peritonitis
> Pain improved in arm following
> backslab

> P/ D/C home
> Follow up with Ortho Clinic
> (signed) Dr McMellon'

This entry was intended by Dr McMellon to reflect what had happened at the review. It will be observed that the note says nothing about the history of the fall, if any, that Leila gave Dr Pearton. Nor does it say anything about whether any observations were made by either doctor in respect of Leila's vital signs, except there is a general reference to nil signs of peritonitis which of course could be confined to clinical signs. The note's purpose was essentially to record the reasons why Leila was discharged despite her earlier presentation.

11.5. Before dealing with the evidence of Dr McMellon and Dr Pearton on this issue I should point out that Mr and Mrs Harkin, both in witness statements and in their oral evidence, candidly stated that Leila had shown some improvement by the time she came to be reviewed by Dr Pearton. Mr Harkin in particular told the Court that he was able to humour Leila by reference to her backslab and the attention she might receive from her friends in respect of it. As well, his statement suggested that Dr Pearton was also able to humour Leila. By then Leila had been administered two quantities of analgesia, namely the 400mg of paracetamol to which I have already referred and 300mg of ibuprofen that had been administered at 12:45am. As well, there ought to have been some relief from the backslab.

11.6. Dr McMellon was called to give oral evidence on 15 December 2015 which was two months and two weeks after Leila's death. At the request of Mr and Mrs Harkin's counsel, Ms O'Connor SC, Dr McMellon would give evidence for a second time, some twelve months later in December 2016. On the first occasion on which she testified, Dr McMellon was asked to describe what Dr Pearton did. This account was Dr McMellon's uninterrupted and sequential version of Dr Pearton's actions in respect of Leila during the course of the review. She said as follows:

> 'She then examined Leila, so first she started with her sitting up and she felt along the flanks at the back and that seemed to be okay, so Leila didn't have any pain then. Then she started round the front with her sitting up and she palpated towards the midline to the central area and that didn't cause her any pain. Then she had her lay down flat and again it was okay where it was soft and non-painful along the sides of the abdomen, but then when she went towards the central aspect, that's when Leila said she did have some pain there. Then following this she got her to get out of bed and they played a jumping game where Leila was jumped four times about - into the air vertically about 30cm, you know

> about a ruler length and laughed and giggled the whole time and said that there was no pain when she did that. Then Elissa asked Leila how did she feel, did she want to go home and Leila said yes she did want to go home. So then Elissa then told her parents that she thought that the abdomen walls, the muscles - sorry the muscles on the abdomen had been bruised and that was what had been causing her pain and that it should continue to get better. But if she started to vomit again or if the pain returned or worsened, then it meant that she needed to be reviewed.'

Dr McMellon was asked some further questions by her counsel in order to elicit some further detail.

11.7. It will be noted that from Dr McMellon's above account that there is no mention of Dr Pearton taking any history from Leila or from anyone else about the fall. Nor is there any reference to Dr Pearton checking Leila's vital signs, say, with the use of a stethoscope that would be utilised to auscultate heart rate. Nor was any further evidence adduced about those issues in Dr McMellon's evidence-in-chief.

11.8. In cross-examination material differences between Dr McMellon's account of the review and that of Dr Pearton, as contained in her witness statement and retrospective progress note, would be revealed. In cross-examination by Dr Pearton's counsel, Mr Bonig, Dr McMellon said that Dr Pearton asked Leila whether or not there had been any rocks or any pointy objects that she had landed on and Leila replied that she had only landed on bark chips to her knowledge[89]. Dr McMellon asserted that Leila had been consistent with the circumstances of her fall throughout[90], and that had involved the fact that she had landed on her abdomen. Having regard to what Dr Pearton's witness statement asserted, as earlier seen, Dr McMellon was asked whether if Leila had been asked '*did you fall on your tummy?*' and she had said '*no*', this would have been inconsistent with what she had already said and be incorrect. To this Dr McMellon agreed that it would be inconsistent. She said that during Dr Pearton's review no person in her presence asked her that question and that Leila did not give a negative answer. The same applied in relation to the question '*did you fall on your chest?*'[91]. In fact Dr McMellon said that if Leila had made denials that she had fallen on her abdomen she would have corrected Leila and would have pointed out to Dr Pearton that her belief was that indeed there had been an impact to Leila's stomach.

[89] Transcript, page 163
[90] Transcript, page 215
[91] Transcript, page 216

11.9. Dr McMellon also said that she had no recollection of Leila's parents correcting their daughter about any erroneous or inconsistent statement that she may have made to Dr Pearton.

11.10. Also in cross-examination Dr McMellon acknowledged that she had not taken another set of observations herself, that she had not seen a nurse take another set of observations and that she had not seen any other person take another set of observations[92]. In answer to specific questions from counsel assisting, Ms Kereru, Dr McMellon asserted in her evidence that during Dr Pearton's review, Dr Pearton did not take Leila's temperature, that she did not listen to Leila's abdomen with a stethoscope, that she did not listen to Leila's chest with a stethoscope and that she did not see Dr Pearton write down a set of observations on a note or on her hand or on anything else[93]. Dr McMellon was at no time challenged about any of those assertions, and in particular by Dr Pearton's counsel, Mr Bonig. Specifically, at no stage during her oral evidence was it suggested to Dr McMellon that Dr Pearton had verbalised either that Leila's heart rate on auscultation by use of a stethoscope was normal or that her respiratory on auscultation by use of a stethoscope was normal. Nor was any figure for either the heart rate or respiratory rate announced. Again, this evidence was not challenged by counsel for Dr Pearton.

11.11. Dr Pearton provided to the Inquest a statement[94] made to her solicitor dated 11 December 2015 and gave oral evidence on two separate occasions, the first occurring on 15 December 2015 following Dr McMellon's evidence and the second in December 2016. I have already referred to parts of her statement, as well as to her retrospective note. Dr Pearton obtained an Honours Degree in Bachelor of Medicine and Bachelor of Surgery from the University of Tasmania in 2009. At the time with which this inquest is concerned she had been working at the WCH for approximately eight months. In October 2015 she was the Emergency Department Fellow. Dr Pearton explained in her evidence that the position of Fellow entails the duties of a senior registrar. She would see patients herself and would supervise junior medical practitioners. She was also involved in the teaching of junior medical practitioners. Dr Pearton explained that she was on a pathway through a training program with the College of Emergency Medicine as a dual trainee, both in paediatric emergency medicine and emergency

[92] Transcript, page 192
[93] Transcript, page 205
[94] Exhibit C15a

medicine. She told the Court that she expected to finish her training in about four or five years. As part of her ongoing training she has held a number of positions at a variety of hospitals both in Tasmania and South Australia.

11.12. On 29 September 2015 Dr Pearton commenced her shift at around 4:00pm and was due to finish at about 1:00am the following morning. On duty that evening was one other more senior doctor than she and this was Dr Neil Smith who was the emergency consultant. Dr Smith did not have any involvement in Leila's management.

11.13. Dr Pearton, both in her statement and in her oral evidence, explained how she came to review Leila. Prior to seeing Leila, Dr Pearton had conducted a number of conversations about Leila with Dr McMellon. At about 11:50pm Dr McMellon had told her that Leila had fallen off a swing, that she had pain in her tummy, chest and arm and that she had not had any pain relief at that stage. Dr McMellon had the patient's notes and nursing observation sheet. Dr Pearton asserts that Dr McMellon opened the observation chart in which she read that Leila had a temperature of 36 degrees, that she was tachycardic and that her respiratory and her blood pressure were slightly high for her age. As seen earlier, the temperature written by Ms Defrancesco was in fact 38 degrees. In her oral evidence Dr Pearton told the Court that in essence she made exactly the same mistake as Dr McMellon and did so quite independently of Dr McMellon in the sense that she also misread the figure of 8 believing it was a 6. She did not see the clearer figure written by Ms Defrancesco on the nursing assessment and observation document, namely '*Temp 38*'. In any case Dr Pearton asserts in her statement that Leila's observations in her view were consistent with the fact that she was upset and in pain, noting that she had a pain score of 7/10 that equates to '*hurts a lot*'. She says that she expected those levels to return to normal with pain relief. Dr Pearton recommended pain relief and x-rays of the chest, abdomen and left arm.

11.14. At about 12:30am at Dr McMellon's request, Dr McMellon and Dr Pearton again discussed Leila. At that point Dr McMellon was in possession of the x-rays. It was correctly agreed between them that the chest and abdominal x-rays were normal. There is no suggestion that this assessment was inaccurate. The question is whether there was any value in the x-ray results having regard to the high incidence of false negatives. I deal with that in another section. However, a buckle fracture was noted on the left distal radius and so a backslab was recommended.

11.15. At 12:50am Dr McMellon and Dr Pearton again discussed Leila. Dr Pearton asserts that at that stage Dr McMellon said that Leila was doing better but that her pain was not completely resolved and she thought that Leila may still be tender in the abdomen on examination. Dr Pearton then suggested that she examine Leila.

11.16. In Dr Pearton's handwritten retrospective notes compiled on 1 October 2015, she recites the detail of what Leila had said during the review about the circumstances of her fall. It states:

> 'On an swing, jumped off swing, fell landing on her left outstretched arm – on further questioning denies landing on her chest or abdomen, denies being hit in her chest or abdomen with the swing.'

11.17. In her witness statement Dr Pearton sets out a direct speech account of the conversation that she says she conducted with Leila in the presence of her parents in cubicle 1. I have referred to this already, but it is as well to set the passage out in full. It is as follows:

> 'I remember that Leila was sitting in between her mother and her step-father on a chair in cubicle 1. I introduced myself, and Leila and I had a conversation in the presence of her parents along the following lines: 'I hear that you've hurt yourself at childcare today' and she said 'Yes'. I said 'Well can you tell me what happened?'. She said that she fell off a swing. I said 'Did you fall off the swing or did you jump off the swing?' and she said 'Well, I jumped, but I fell'. I asked 'Did you fall on your chest?' and she said 'No'. I said 'Did you fall on your tummy?'. She said 'No'. I said 'Did you fall with your arms out?' and she said 'Yes'.
>
> I also asked whether the swing had hit her in the chest or the tummy or whether she had landed on anything when she went down onto the ground and she said 'No just my arm'.
>
> I also asked Leila whether she still had pain or whether she was feeling better and she said that she was feeling better. At that point I got her to hop up onto the bed to examine her.'

11.18. The statement then goes on to describe the examination. As has earlier been observed, the denials that Leila allegedly made to the effect that she had neither fallen on her chest nor on her tummy were contrary to all that had been said and understood prior to this review. Furthermore, as seen, this was something that if said completely eluded Dr McMellon and Leila's parents as well. To my mind such a scenario is highly unlikely. It should have been assumed by Dr Pearton for the purposes of this review that Leila had landed on her stomach as that this was where the pain was emanating from. The inclusion of the account of what Leila allegedly said about her fall in both Dr Pearton's retrospective notes and in her witness statement could only have been

intended to create an impression that Dr Pearton, as part of her review, had acted on the basis that Leila had not fallen on her stomach and that this had been a matter that she had taken into consideration in determining that it was unlikely that Leila had sustained a serious internal injury. In her oral evidence Dr Pearton said that from her interaction with Leila she had the impression that she had gone to jump off the swing but had fallen and that she had fallen onto an outstretched hand which had broken her fall and then onto her stomach and that she did not fall onto any other big or hard object that had hit her in the stomach[95]. In cross-examination by Ms Kereru, counsel assisting, she also said that she had been reassured that the landing was not as hard as it could have been. She said that she had deduced that Leila had fallen onto the outstretched hand which 'then further cushioned the blow', but taking into account that a child very rarely would fall directly onto their hand without falling onto another part of their body[96]. I do not believe that Leila's one word answers, without further elucidation, would reasonably have borne out such an interpretation in any case.

11.19. The other matter worthy of comment is that even if Dr Pearton had elicited the negative answers that she alleged Leila gave her one would question the degree of reliance that could have been placed on those answers when Dr Pearton on her own admission had not read Dr Man's referral letter nor had properly informed herself of the true circumstances of Leila's fall that had already been the subject of documentation within the WCH. It is of note that this account of Dr Pearton's conversation with Leila is not supported by Dr McMellon, and indeed Dr McMellon stated that Leila provided Dr Pearton with the '*same story that I had*'[97]. Mrs Harkin gave evidence that there was conversation between Dr Pearton and Leila about how Leila had come off the swing. Mrs Harkin told the Court that she could not recall exactly what Leila had said but that from her answers there was nothing that she felt she needed to correct. Her account was consistent with what Leila had said before and was consistent with Mrs Harkin's own understanding of how the fall had occurred. Her understanding was that Leila had bellyflopped on her stomach which was a description given by Ms Trebilco and one that matched Leila's own account of this event. Mr Harkin told the Court that he did not recall Leila saying much during this examination and did not recall her saying what part of her body she had fallen on. However, if Leila had said to Dr Pearton that she

[95] Transcript, page 242
[96] Transcript, pages 282-283
[97] Transcript, page 202

had not fallen on her stomach, this would have been inconsistent with his own understanding of Leila's accident, and that if Leila had said this to Dr Pearton he would have corrected Leila and would have demonstrated his understanding of her fall[98]. Mr Harkin told the Court that Leila had told Dr McMellon earlier that she had fallen with her arms out in front of her parallel to the ground in a 'Superman position' with arms stretched out and that she bellyflopped[99].

11.20. I do not accept Dr Pearton's assertions that Leila denied that she had landed on her chest and her stomach or that Dr Pearton reasonably drew any reassurance from whatever Leila said. If from what Leila said Dr Pearton thought that Leila's hand may have cushioned the blow, she would also have needed to take into consideration the possibility that it was her hand that had done the internal damage that had earlier been rightly suspected. The overwhelming consideration was that Leila had fallen from a significant height and that the forces on her body from an impact from that height must have been considerable. It was clear beyond argument that Leila had fallen onto her front and that the impact to her abdomen must have been significant regardless of whether her hand or arm had intervened between the ground and her abdomen. How a fall that had been quite concerning to Dr Man and the triage nurse could have transmogrified into something supposedly quite benign in Dr Pearton's eyes is beyond the comprehension of this Court. Dr Pearton, of course, did not read Dr Man's letter, but she acknowledged in her evidence that the letter contradicted the history that she herself had obtained from Leila, and yet Dr Pearton asserted that she did not think Dr Man's letter would have changed what she did with Leila[100]. I do not fully understand why Dr Pearton's account of what Leila said about her fall is so at odds with everything that had been said and understood to that point other than that she has attempted, consciously or otherwise, to minimise the significance of the circumstances of Leila's fall when all along it was to that point understood that Leila had experienced a fall from a significant height and must have sustained a substantial impact with her abdomen. Be that as it may, the account given by Dr Pearton to my mind speaks of an unreliability on her part that permeates the rest of her account of what happened during this review. In short, I have been unable to place complete reliance upon Dr Pearton's

[98] Transcript, page 615
[99] Transcript, page 616
[100] Transcript, page 288

evidence where it differs from the evidence of others, particularly Dr McMellon and Leila's parents.

11.21. There are three other aspects of Dr Pearton's review that are of some importance. They are, Dr Pearton's belief as to the temperature that Leila had displayed when first assessed by the nursing staff, the so called jump test that she asked Leila to perform and the vital sign observations that Dr Pearton asserts that she made during the course of this review.

11.22. Dr Pearton's handwritten ex post facto progress note refers to Leila being '*Afebrile 36*'. Dr Pearton's witness statement also refers to that figure. In her oral evidence on the first occasion in December 2015 she told the Court that she obtained that figure from the observation chart. Dr Pearton understands that the figure is in fact 38. She said that she would have characterised a temperature of 38 as a low grade fever[101]. Dr Pearton asserted that she was told by Dr McMellon that Leila was 'afebrile' and that Dr Pearton herself had misread the figure of 36[102]. She said that Dr McMellon showed her the observation chart and that Dr Pearton also read the figure as 36. Asked as to how she knew that Dr McMellon had read it as 36 she said that if Dr McMellon had read it as 38 she would not have told Dr Pearton that Leila was afebrile as she assumed that Dr McMellon knew what a normal temperature was[103]. There had been no discussion between herself and Dr McMellon as to what the figure actually read. Dr McMellon had simply told Dr Pearton that Leila was afebrile without putting a figure on it[104]. It therefore appears that Dr Pearton independently of Dr McMellon made exactly the same error, an astonishing coincidence.

11.23. Dr Pearton was questioned as to what may have occurred if she had correctly understood that Leila had exhibited a temperature of 38, and was therefore febrile, when she had been assessed by the nursing staff. Dr Pearton said a number of things about that issue. Asked as to the significance that she would have attributed to a temperature of 38 she said it would have led her to recheck the temperature to ensure that it was coming down, but then added that without any other clinical signs on examination at that point she would not have attributed any significance to that temperature[105].

[101] Transcript, page 273
[102] Transcript, page 274
[103] Transcript, page 285
[104] Transcript, page 286
[105] Transcript, page 273

Dr Pearton acknowledged that a temperature of 38 could suggest an infection[106]. In answer to counsel assisting's question as to whether she would have taken Leila's temperature just before she was discharged if her temperature had been correctly understood as 38, Dr Pearton said that she would have ensured that Leila's temperature had normalised. This of course presupposes that her temperature would have normalised at the time Dr Pearton examined her. There is no way of knowing whether that would have been the case.

11.24. Dr Pearton asked Leila to perform a test known as a jump test. There was divergent evidence about the number of jumps that Leila was asked to perform. The idea behind the jump test was that it might elicit pain indicative of an internal injury. There is no doubt that Leila performed a jump or jumps and that her reaction was not in any way extreme. The value of the jump test was the subject of further evidence. Dr Pearton, for one, appeared to have placed much significance on the test. It occurs to the Court that the reaction of a patient to such a test could hardly be determinative where there are or have been other signs and symptoms of an internal injury. Otherwise, the jump test would be the only test applied. I will deal with issue in greater detail when discussing the expert evidence.

11.25. I have found that Leila already had the backslab applied by the time she came to be reviewed by Dr Pearton.

11.26. As to the set of observations that Dr Pearton said she made, in her handwritten ex post facto progress note she wrote that Leila's heart rate on auscultation was 100 beats per minute and her respiratory rate on auscultation was 20 respirations per minute, both of which would be classed as normal. I have already referred to Dr McMellon's evidence about this issue, evidence that was given before Dr Pearton gave evidence. She had said she knew nothing of this. In her evidence Dr Pearton said that she used a stethoscope in order to auscultate heart rate and respiratory rate. Neither Mrs Harkin nor Mr Harkin observed, or at least recalled if they did in fact observe, the use of a stethoscope at any stage during this examination by Dr Pearton. At first, Mrs Harkin said categorically that Dr Pearton did not use a stethoscope against Leila's chest or abdomen[107]. She resiled somewhat from this position as will be seen. But she was adamant that nothing was said about Leila's vital signs being normal or abnormal after

[106] Transcript, page 274
[107] Transcript, page 399

Dr Pearton came into the room. If correct, this would be somewhat surprising because if the observations had been normal, Dr Pearton's announcing that would no doubt have been reassuring to Leila's parents. So why not announce it? Dr Pearton said in her evidence that she did say to Dr McMellon that the observations were normal, but Dr McMellon denied that and certainly made no note of it. I return to this issue.

11.27. In cross-examination by Dr Pearton's counsel, Mr Bonig, Mrs Harkin said this:

> 'I was paying attention, however it was late at night, it was – around 1:30. It had been an extremely long day and my memory as you have – as thought it has been quite clear is patchy at times, but I don't have a recollection of anything happening other than the use of hands on Leila's torso on behalf of Dr Pearton.'

Mrs Harkin then appeared to concede that although she had no recollection of Dr Pearton doing anything other than using her hands on Leila's torso, this did not mean that Dr Pearton had not used her stethoscope to listen to Leila's chest[108]. She conceded that it had been a long day and that she had been tired at that point.

11.28. Mr Harkin was unshaken on the issue. He said in evidence that during the examination he was in a position in which he could see what Dr Pearton was doing in respect of Leila. He stated that he watched the examination for its entirety[109] and that he did not see Dr Pearton use any device of any kind including a stethoscope on Leila's chest or abdomen. He stated categorically that Dr Pearton did not at any stage use a stethoscope. He stated that he would have been in a position to see that if it had occurred. He said:

> 'Because I'm standing up, and I'm 6'2, I'm pretty tall, I'm looking down at everything, I'm observing what's happening with my daughter.'

He said that there was no object between him and Dr Pearton and Leila. Asked as to his level of certainty or otherwise about the issue of the use of the stethoscope he said that he was 100 percent certain that it was not used [110]. He said it was not possible that the stethoscope was used and that he did not observe it. Similarly, he said that it was not possible that she used a stethoscope but that he had since forgotten[111]. Challenged by counsel for Dr Pearton, Mr Harkin said that if a stethoscope had been used he could have seen the stethoscope quite easily. He denied that his view may have been

[108] Transcript, page 436
[109] Transcript, page 622
[110] Transcript, page 628
[111] Transcript, page 628

obscured. He also rejected the suggestion that he had convinced himself about certain matters based on a subsequent reconstruction of events. He said:

> 'I've thought about this and from what I've said is since it happened bits of it, certain aspects of the whole 48 hours or whatever it has been playing on my mind. So, I don't think so, I believe in my mind what I'm telling is how I remember it, you know.' [112]

11.29. In assessing the credibility of Mr and Mrs Harkin I took into consideration the fact that before Mr and Mrs Harkin gave their oral evidence they had been in Court and had listened to the evidence given on the topic of the stethoscope by Dr McMellon and Dr Pearton. I took into account the possibility that both Mr and Mrs Harkin, in order to advance their own interests in this matter, would have been more inclined to align themselves with the evidence given by Dr McMellon that no stethoscope was used and that no observations of Leila were taken by Dr Pearton.

11.30. I should here say something about an unusual development that took place in the course of this Inquest. At the request of Mr and Mrs Harkin's newly appointment counsel, Ms O'Connor SC, I agreed, with some hesitation, that Dr McMellon and Dr Pearton be recalled in order to provide Ms O'Connor with the opportunity to cross-examine both doctors in respect of certain matters. Ms O'Connor SC had not been involved in the Inquest at the time Dr McMellon and Dr Pearton had given their original evidence in December 2015. As events unfolded, and due largely to the convenience of counsel involved in the Inquest, Dr McMellon and Dr Pearton were not recalled until December 2016.

11.31. Dr McMellon was recalled first. When Dr McMellon was recalled she was cross-examined in the first instance by Ms O'Connor SC. In the course of her examination Ms O'Connor asked Dr McMellon how many times Leila's heart had been checked at the WCH to which Dr McMellon said:

> 'Well I auscultated her chest when I first saw her and I know Elissa also auscultated her chest when she came and saw her but other than that I don't know of any other recordings other than the nurses recording.' [113]

Asked as to the means by which Dr Pearton has auscultated Leila's chest she said '*I remember her using a stethoscope*'[114]. It will be noted that the information that

[112] Transcript, page 700
[113] Transcript, page 938
[114] Transcript, page 938

Dr Pearton had auscultated Leila's chest using a stethoscope was not elicited by any leading or loaded question on the part of cross examining counsel. Secondly, this was the first time that Dr McMellon had ever asserted in my Court that Dr Pearton had listened to Leila's chest with a stethoscope. Indeed, as has already been seen, when Dr McMellon had given evidence twelve months previously she had denied that Dr Pearton had used a stethoscope. Later in cross-examination during Dr McMellon's recall to the witness box, Dr McMellon stated that from what she recalled she thought that Dr Pearton had listened to Leila's chest on her back[115]. She was asked the following question and gave the following answers:

> 'Q. So, she used a stethoscope for listening.
>
> A. I think so.
>
> Q. You can't remember that.
>
> A. What I remember it was a stethoscope, but this is more than a year ago.
>
> Q. Because there's a machine in that room, isn't there –
>
> A. Yes
>
> Q. – that you can actually just put a clip on a child's finger and it will tell you the heart rate.
>
> A. Yes
>
> Q. That wasn't used by Dr Pearton, was it
>
> A. I don't know. I don't remember that being used, but I don't remember it not being used.'

In further cross-examination by Ms O'Connor Dr McMellon said that she did not remember whether Dr Pearton was looking at her watch when she listened to Leila with a stethoscope, which would normally be necessary in calculating heart rate. She could not remember Dr Pearton writing anything down or telling Dr McMellon to write anything down about the observations that Dr McMellon had taken[116]. Dr McMellon admitted that she did not ask Dr Pearton what Leila's heart rate was at that point in time[117]. Dr McMellon acknowledged that if Leila's heart rate had descended to 100 beats per minute from the heart rate at the Strathalbyn Hospital and then earlier at the WCH, this would have represented a significant improvement. Dr McMellon said '*it would have been something useful to have known yes*'[118]. Asked to expand on that Dr McMellon acknowledged that a set of observations taken by Dr Pearton prior to

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[115] Transcript, page 951
[116] Transcript, page 956
[117] Transcript, page 956
[118] Transcript, page 958

discharge would have at least had been as important as all other previous observations[119]. She also acknowledged that the normality of Leila's observations at the least would have been a contributing factor in the decision to discharge her[120]. She also acknowledged that if the observations had remained the same as they had been, that is to say abnormal, the decision to discharge would have been all the more difficult. In fact she added that one may have delayed her discharge in those circumstances[121]. And yet Dr McMellon could not explain why these normal observations were not recorded at the time[122]. Equally, there does not appear to be any sensible explanation as to why Dr McMellon would not have been made aware of the nature of those observations. To my mind any suggestion on Dr McMellon's part that she observed Dr Pearton using a stethoscope is contradicted by the fact that she was never made aware of the results of whatever Dr Pearton was doing with the stethoscope, results which would hardly have been a secret.

11.32. Naturally Dr McMellon was questioned about the evidence that she had given previously on this topic. Ms O'Connor asked Dr McMellon why she had changed her story. To this Dr McMellon said '*because I can't quite remember exactly what happened, so if I said 'no' last time, well then I'd want to say 'no' again this time.*' [123] The 'no' to which Dr McMellon was referring was a reference to the negative answers that she had given on the previous occasion on which she had given evidence to questions whether Dr Pearton had listened to Leila's abdomen and chest with a stethoscope. Dr McMellon added this:

> 'I remember her doing an examination and in my mind she used a stethoscope but then apparently I didn't think that last time so I'm happy to say whatever I said last time would be the more accurate because that was closer to the event.'

Dr McMellon then went on to say that she did not want to sound as though she was creating a memory. She said that in her mind Dr Pearton must have used a stethoscope but added that whatever she, Dr McMellon, had said in evidence on the previous occasion would be more accurate[124]. She was then asked by Ms O'Connor SC:

> 'Q. So is your evidence now she did not use a stethoscope because 'that's what I said last time and my memory would have been more accurate.' Is that your evidence.

[119] Transcript, page 963
[120] Transcript, page 962
[121] Transcript, page 962
[122] Transcript, page 963
[123] Transcript, page 965
[124] Transcript, page 966

A. Yes.

Q. 'And I said today she used a stethoscope' because that's what she probably should have done.

A. Well, she probably should have done that then.'

Further, Dr McMellon said that what she was saying is that she did not know how much of her evidence was her thinking that she remembered Dr Pearton examining Leila's chest as against her knowledge that she was examining parts of Leila, and she said '*so it's hard to say*'[125]. She pointed out that it was more than a year ago.

11.33. In assessing Dr McMellon's answers I took into account the pressure that Dr McMellon must have under in having to be examined, this time with hostility, for a second time a year after the first occasion. I also considered whether the quality of her answers to counsel's questions had been the product of badgering. I would reject that. If so, I would have stopped the cross-examination. To my mind what was clear was that Dr McMellon had no active recollection, nor ever has had an active recollection, of Dr Pearton using a stethoscope or of taking vital sign observations in that fashion or by any other means. It will also be observed that Dr McMellon herself suggested that she would rely on her earlier version because that was given closer to the episode in question[126]. In cross-examination by counsel assisting Ms Kereru, Dr McMellon denied that since giving evidence on the first occasion Dr Pearton had raised with her the issue about her having used a stethoscope or otherwise[127]. However, on further questioning by Ms O'Connor, Dr McMellon acknowledged that since giving evidence on the first occasion she had heard that Dr Pearton had said that she took Leila's observations as part of her review[128]. She also acknowledged that she knew that there were differences between what she had said on a previous occasion and what Dr Pearton had said[129]. To my mind the possibility that Dr McMellon's more recent equivocation about whether she did or did not recall Dr Pearton using a stethoscope to take Leila's observations had been influenced by what she knew and had since heard about Dr Pearton's stance on that subject, is a possibility that cannot be eliminated. At best Dr McMellon's answers display a mere assumption on her part, unsupported by recollection, that Dr Pearton would have taken Leila's vital sign observations, an assumption that would not be

[125] Transcript, page 967
[126] Transcript, page 974 and 975
[127] Transcript, page 1003
[128] Transcript, page 1008
[129] Transcript, page 1009

surprising given that a failure on the part of Dr Pearton to have done that would amount to an egregious oversight.

11.34. On the subject of whether Dr Pearton had taken a set of observations from Leila during her review, and the nature of those observations, the colorectal surgeon Dr Nicholas Rieger gave some relevant evidence. He was asked whether having regard to Leila's earlier observations, and even allowing for the fact that the temperature was wrongly interpreted as 36, what the likelihood would have been that normal observations such as 100 heart beats per minute and 20 respirations per minute were in existence just before Leila was discharged. Dr Rieger said this:

> 'It's out of keeping with the other documentation. The likelihood of that being how it was – so this I assume is when the fellow has seen Leila, so that's at review after analgesia and after the x-rays have been taken – it's a vast improvement on what the original observations were. Given that we know a small bowel injury has occurred such that it's perforated and Leila's passed away with peritonitis secondary to that, it just doesn't gel, in my opinion, I'm sorry.'

It will be clear from that answer that Dr Rieger was assuming that Leila had experienced the perforation within her bowel by the time of her attendance at the WCH. As seen, that was certainly his opinion, an opinion I have accepted. The effect of what Dr Rieger was saying there was that in his view the observations purportedly taken by Dr Pearton were out of keeping with the fact that in his view Leila was experiencing peritonitis and with the earlier abnormal observations.

11.35. Other evidence differed from Dr Rieger's on this subject. Associate Professor Raftos made a general comment about the likelihood or otherwise of Dr Pearton's asserted observations as being accurate. Associate Professor Raftos said that a rapid heart rate and rapid breathing were probably driven by two things, pain and the inflammatory response that the peritonitis provoked. The medications that Leila was given would have damped down both the pain and the inflammatory response for a period of time and so he suggested that it is possible that those observations may have been in the range described simply because the treatment had modified those parameters. He said it was *'plausible'* but could not say whether it would have a 50% effect or a 100% effect. Either way, Associate Professor Raftos suggested that one would need to use caution in interpreting a set of parameters with the knowledge that Leila had been treated with medication[130]. Dr Craven was asked as to how likely it would be that Leila

[130] Transcript, page 1180

would present with a normal respiratory rate and normal heart rate and no pain in less than two hours[131]. Dr Craven's answer appeared to be coloured by his view that peritonitis may not have been in evidence at that time. He was therefore asked to assume that Leila in fact did have the early signs of peritonitis and that her original observations were reflective of that and if in that event how likely it would be that Leila would present with normal respiratory and heart rate and no pain only two hours after her original observations were taken. Dr Craven suggested that this was quite possible. He added that it would depend on what the original fast respiratory rate and the fast heart rate had been. He also added '*if they are due to the temperature, as I said earlier, and the temperature settles down, then the other symptoms will also settle as well*'[132]. The difficulty of course is that there is no means of knowing whether or not Leila's temperature did settle down because it was only taken on the one occasion. Dr Craven did agree that if Leila had peritonitis '*things shouldn't have gone better*'[133]. In light of that answer, Dr Craven was again asked as to the likelihood of Leila having normal parameters and not being in the significant pain, this time on the premise that Leila had peritonitis at the WCH and that the original signs and symptoms were reflective of that. To this Dr Craven said that it was *'unlikely but possible'*[134]. To my mind Dr Craven's evidence did not significantly advance the resolution of this issue having regard to his concession that if peritonitis had been present it is unlikely that Leila's heart and respiratory rate and pain would have subsided. Furthermore, the unknown element in this is Leila's temperature which was not taken at the time of the review nor at any other time after her arrival and initial assessment at the WCH. In the event I have preferred the evidence of Dr Rieger on this issue. Dr Rieger's speciality is abdominal pathology and his expertise is in bowel trauma. To my mind his opinions in respect of the issue under discussion are to accorded more weight than those of Drs Raftos and Craven. I have found that Leila was experiencing the effects of peritonitis and that her original observations were reflective of that. Accordingly, accepting the evidence of Dr Rieger as I do on this subject, to my mind it is unlikely that Leila's vital signs would have descended to the levels that Dr Pearton asserts.

11.36. Finally on the topic of the congruity or otherwise of Dr Pearton's purported vital sign observations there is the evidence of Ms Defrancesco in which she asserts that she saw

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[131] Transcript, page 739
[132] Transcript, page 740
[133] Transcript, page 740
[134] Transcript, page 740

Leila's the monitor reflecting a heart rate at a more normal level. Ms Defrancesco did not make a note of what could have been a reassuring development, a development that the medical staff might have wanted to know. In fact, no note was ever made of any further vital sign observation. Hers was a vague assertion and I place little weight on it. It does not reduce my confidence in my acceptance of Dr Rieger's opinion that Leila was experiencing peritonitis at the WCH and that Dr Pearton's purported observations do not gel with that scenario or with the earlier abnormal observations.

11.37. For the moment I put to one side Dr Rieger's opinion. It is to be acknowledged that Mrs Harkin appeared to concede that she may have missed the use of a stethoscope due to fatigue. However, I am satisfied that she has no recollection of the use of a stethoscope and I am satisfied that she has not deliberately suppressed any knowledge on her part as to the use of a stethoscope. That of itself, of course, would not disprove that a stethoscope was not used. On the other hand, Mr Harkin was adamant that it was not used. I found the evidence of Mr Harkin on this topic to be credible. It coincides with the evidence of Dr McMellon whom I can assume was being observant at the time of the review, a review that she says was instigated by her because of her remaining doubts about Leila's condition. I believe that the original evidence given by Dr McMellon on the subject of the use of a stethoscope was accurate and I prefer it to her equivocation a year later in the knowledge that the subject had become an issue in the Inquest. Her denials that a stethoscope was used by Dr Pearton were made close to the event. To my mind Dr McMellon's original evidence that a stethoscope was not used stands as her evidence on the subject of the use of a stethoscope. I regard that evidence as her definitive evidence on the subject and I accept that evidence. Dr McMellon never seriously suggested that she had been wrong in giving that evidence. As I say, I reject the notion that Dr McMellon has, or ever has had, an active recollection of Dr Pearton using a stethoscope. She had no such recollection in December 2015 when she originally gave evidence. I am reinforced in my belief that Dr McMellon originally told the truth about this subject, and that she was reliable in her denials that a stethoscope was used by Dr Pearton, by the fact that Dr McMellon made no note that vital sign observations were taken during the review, nor of the result of those observations nor of any specific figures that were identified in respect of Leila's vital signs when those matters were just as important as all of the other information that she recorded in her note. Moreover, as seen, it is significant that Dr McMellon made no mention of the taking of vital signs when for the first time she

was asked by her own counsel to describe in sequence and in detail what happened during the review. I have taken into consideration that Dr McMellon's equivocation during her second episode of giving evidence might suggest that her credibility has been significantly damaged, or that her original evidence has thereby been neutralised, and that I should therefore be cautious about relying on any aspect of her evidence where it conflicts with other evidence. I have exercised due caution in relation to Dr McMellon's credibility but I am satisfied that she was telling the truth when she first gave evidence and told the Court that Dr Pearton had not used a stethoscope. I have also considered a number of competing reasons why Dr McMellon would have denied that Dr Pearton had taken Leila's vital signs using a stethoscope if the truth was otherwise. I have considered the possibility that Dr McMellon was lying on that first occasion. I do not believe that this is a realistic possibility. In many senses it would have been against Dr McMellon's own personal interests to have deliberately falsely denied that Dr Pearton had performed this important function. I can detect no reason why she would choose to deliberately conceal Dr Pearton's taking of vital sign observations by use of a stethoscope other than, say, if she had been embarrassed at not having made a record of that occurrence. But the embarrassment of having failed to draw Dr Pearton's attention to the need to take vital sign observations, something that Dr McMellon should have done if she is correct that no vital sign observations were taken, would no doubt be the greater embarrassment. I have also considered the possibility that Dr McMellon simply did not pay sufficient attention to what Dr Pearton was doing to have noticed the use of a stethoscope. I reject this as a possibility because the review was essentially driven by Dr McMellon's own concern that Leila not be discharged without the review taking place. If Dr McMellon was not paying attention to what Dr Pearton was doing, then it begs the question as to what Dr McMellon was doing. I am certain that she would have paid sufficient attention to what Dr Pearton was doing to have noticed if a stethoscope was used. Furthermore, Dr Pearton said in her evidence on the second occasion that she told Dr McMellon that Leila's observations were normal although she could not recall telling her the exact numbers[135]. If that exchange truly occurred was Dr McMellon oblivious to that as well? I think not. I have also considered the possibility that by the time Dr McMellon came to give her evidence on the first occasion in December of 2015 she had forgotten that Dr Pearton had used a stethoscope. I do not believe this is possible. It is unthinkable that news of

[135] Transcript, page 1054

Leila's death would not have stimulated a measure of concern on Dr McMellon's part. She had been present at, if not been part of, the decision to allow Leila to be discharged. The matters that went to that decision would have remained uppermost in her mind. I cannot believe that a person in Dr McMellon's position could have forgotten that vital sign observations were taken, or that a stethoscope had been utilised for one purpose or another, as part of a decision making process of which she was part. And if she had observed observations being taken, then one has to return to the question, why did she not make a note of the observations, or at least of the fact that they had been taken just prior to discharge? There is a fourth possibility, and that is that under the understandable pressure and stress of the witness box on the first occasion Dr McMellon made an error. The difficulty with this possibility is that the error was made on more than one occasion in the course of her original evidence. As well, I know of no effort on Dr McMellon's part to correct the record at any stage prior to her giving that very vague evidence on the second occasion, and as I say, I do not believe that Dr McMellon has or has ever had an active recall of Dr Pearton using a stethoscope. For all of those reasons it is my belief, and I find, that when Dr McMellon told the Court on the first occasion that Dr Pearton had not used a stethoscope she had been telling the truth and had been accurate.

11.38. I have rejected Dr Pearton's evidence that she used a stethoscope to measure Leila's heart rate and respiratory rate. I was unimpressed by Dr Pearton's attempt to minimise the circumstances of Leila's fall and the force of the impact that Leila must have sustained. It reduced my confidence in respect of her ability to provide an accurate and reliable account of what transpired in the review. I find that Dr Pearton did not use a stethoscope during her review of Leila and did not observe her vital signs of heart rate and respiratory rate. I find that no other means was used to take Leila's observations during the course of Dr Pearton's review. I find that Dr Pearton discharged Leila on the basis of her clinical impression of Leila and on her response to the jump test. I make these findings on the balance of probabilities, but I do so conscious of the gravity of those findings, particularly the finding as to whether or not Dr Pearton took Leila's observations by use of a stethoscope, and conscious of the admonitions within the well-known authority of **Briginshaw v Briginshaw** (1938) CLR 336. A finding that Dr Pearton did not take Leila's observation before discharge would amount to a serious finding on a number of levels including that it would be a reflection upon her professional competence as well as a reflection on her honesty having regard to the

contents of her retrospective note, her witness statement and her evidence in this Court given on two occasions under an affirmation. In accordance with **Briginshaw** I have directed myself that the standard of proof required by a cautious and responsible tribunal naturally varies in accordance with the seriousness of the importance of the issue. I regard the issue that I have identified as one that is both serious and important. I have also directed myself that this Court should not act upon mere suspicion, surmise or guesswork. I have also directed myself that the seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of this Court. I am conscious of the fact that reasonable satisfaction should not be produced by inexact proofs, indefinite testimony, or indirect inferences. I have also taken into consideration the submissions of Dr Pearton's counsel, Mr Bonig, particularly as they relate to the reliability of Mr and Mrs Harkin in respect of the issue under discussion as well as generally. I have considered Mr Bonig's submissions in relation to the equivocation that Dr McMellon exhibited in the witness box on the second occasion that she gave evidence and how that might affect her reliability. As indicated above, I have carefully considered the totality of Dr McMellon's evidence and I am perfectly satisfied for the reasons I have given that on the first occasion on which she gave evidence in December 2015 she was telling the truth in respect of the issue regarding Dr Pearton's use of a stethoscope and that her evidence was accurate on that issue. It is true that in other instances I have found Dr McMellon's evidence difficult to accept, for example where she asserted that she derived reassurance from her understanding as to the circumstances of Leila's fall. I have considered whether that aspect of her evidence tainted the rest of her evidence, but I have directed myself throughout these proceedings both in relation to her evidence, Dr Pearton's evidence and the evidence of Mr and Mrs Harkin that a tribunal is not obliged to accept or reject a witness's evidence in its entirety. As I say, for the reasons identified above I was perfectly satisfied that on the first occasion Dr McMellon gave evidence she accurately told the truth about the issue of the stethoscope. Her evidence on that issue was supported by that of Mr Harkin in particular. I indicate that in coming to the findings here under discussion I have taken into account the evidence of Dr Rieger to the effect that Dr Pearton's figures of heart rate and respiratory rate would seem to represent an intrinsically unlikely scenario having regard to the dramatic reduction in the figures

relating to heart rate and respiratory rate that had been identified in the first instance. If I am wrong to have taken Dr Rieger's evidence on this issue into account, I indicate that based on the rest of the evidence I am still nevertheless satisfied to a very high level of satisfaction that Dr Pearton did not take Leila's observations by use of a stethoscope.

12. <u>Leila's apparent condition at the time of the review</u>

12.1. The evidence on this issue emanated from a number of sources, most relevantly Mr and Mrs Harkin on the one hand and then Drs McMellon and Pearton on the other.

12.2. For these purposes it is important to keep in mind Leila's condition when she arrived at the hospital and also her condition when seen by Dr Man at the Strathalbyn Hospital. It is also important to consider that for the ten hours prior to Leila's arrival at the WCH she had been exhibiting signs of illness and had been experiencing significant pain. It is also worth considering that following Leila's discharge she again showed the same signs as she had shown the previous day.

12.3. It is worthwhile examining the relevant parts of the statements that both Mr and Mrs Harkin made on the morning of Leila's death. Mrs Harkin asserted that at about 12:45am the doctors came and saw them. They told Mr and Mrs Harkin that there was a fracture in her left wrist but that the x-rays did not reveal anything else. According to Mrs Harkin they said that Leila's stomach muscles were tight or strained or that she had strong stomach muscles. What that opinion may have been based on is quite unclear if that is an accurate account of what was said. The statement goes on to say that the 'Doctor' came and saw her again and said that she was not happy until Leila's stomach pain was gone. At that point Leila said that it still hurt. The doctor in question would have to be Dr McMellon. The doctor went and obtained another doctor whom we now know to be Dr Pearton. The second doctor got Leila to stand up to examine her. Mrs Harkin asserted in that first statement that she wanted Leila to lie down but it hurt too much so she was asked to stand up. Mrs Harkin asserted that she got Leila to jump which Leila did. The response from the doctor whom we know to be Dr Pearton was to say '*No, she's right. She can go home*'.

12.4. In the statement taken from Mr Harkin on the morning of Leila's death it is recorded that Mrs Harkin told investigating police that following the taking of x-rays they were informed of the x-ray results and of the fractured wrist in particular. She states that the doctor, whom we know to be Dr McMellon, informed them that they would keep Leila

in the hospital until Leila was no longer in pain. The cast was then put on Leila's wrist. Mr Harkin asserts that at that point Leila said she was in too much pain to turn around as requested by a nurse. Mr Harkin stated that following the cast being placed on Leila the doctor again came to the cubicle. At that point Leila was still in pain in respect of her stomach. There was a discussion about the x-ray showing no abnormality and Mr Harkin asserts, like Mrs Harkin, that the doctor said that they would keep her at the hospital until her pain was gone. As to the review by the doctor whom we know to be Dr Pearton, Mr Harkin stated that she was pleasant to Leila and communicated well with her. There was the jumping test administered to which Leila did not complain, but that when the doctor was pressing her stomach Leila responded with the words '*ow, ow, ow*'. Mr Harkin asserts in this statement that following the discharge from the hospital Leila said that her stomach was still sore.

12.5. On an analysis of Mr and Mrs Harkin first witness statements, given at a time when it might be thought they would have no specific reason to fabricate anything, it seems that Leila's pain had not dissipated completely at the time of her discharge and at the time of Dr Pearton's review.

12.6. However, it will be remembered that both Mr and Mrs Harkin in their evidence before the Court acknowledged that Leila had shown some improvement by the time of the review. There is one matter that perhaps I should mention here and it is whether or not Leila consumed some biscuits that were provided. Mr and Mrs Harkin stated that Leila did not eat the biscuits and that a belief by anyone else to the contrary was not correct. It was asserted that Mr Harkin ate the biscuits.

12.7. Mrs Harkin's addendum statement given on 3 November 2015 asserts that the doctor whom we know to be Dr McMellon, at approximately 1:10am gently pushed Leila's abdomen asking where it hurt to which Leila indicated several areas of pain. The doctor then stated that Leila would not be allowed to go until her stomach stopped hurting. Mrs Harkin told the doctor that she was very tired. It was then that the doctor we know to be Dr Pearton came to the cubicle. Here Mrs Harkin asserts in this addendum statement that Dr Pearton examined Leila while Leila was standing as Leila had said that it hurt too much to get up on the bed. There was the jumping test in which Leila executed a small jump. This statement does not describe what Leila's reaction was.

12.8. Mrs Harkin's oral evidence bore some differences from her statement. She said that Leila had been sitting on the bed and that Dr Pearton had asked her to lie flat but that Leila said that she could not do this because it hurt. Leila was then assisted to physically descend from the bed and as she did so Leila was grimacing and looked uncomfortable. Mrs Harkin added that she could see that Leila was trying very hard to cooperate with the doctors and to be brave. It would not be surprising if Leila did exhibit such an attitude at that stage especially if she had wanted to go home. When Dr Pearton examined Leila in a standing up position Leila indicated pain when touched, although Mrs Harkin could not recall what Leila said if anything. As to the jump test Mrs Harkin said that she could not recall Leila saying anything during or after the jump which Mrs Harkin described as a jump of no more than 30 centimetres. Mrs Harkin was asked whether when Leila jumped she laughed and giggled. Mrs Harkin said she could not recall that, but told the Court that earlier Leila, in the absence of Dr Pearton, had been smiling at jokes that Mr Harkin was making about the cast on Leila's arm[136]. Mrs Harkin conceded that there may have been more than one jump[137]. Pressed as to whether she had any recollection of Leila complaining about pain from jumping, Mrs Harkin said that she had no recollection[138]. It occurs to the Court that if Mrs Harkin was lying about Leila's condition during the review she would have taken the opportunity to describe an adverse reaction on Leila's part to the jumping test, regardless of whether it was one or more jumps. To my mind Mrs Harkin was doing her best to tell the truth here.

12.9. Mr Harkin, who was absent when his wife gave oral evidence in December 2015, provided a further statement to police on 1 January 2016[139]. In that statement he asserts that he was joking with Leila about the cast and the possible reaction of her friends to it. This occurred in the cubicle after the cast had been placed on Leila's wrist. When Dr McMellon came into that cubicle she asked Leila about her arm and stomach. He recalled Leila telling Dr McMellon that her arm felt better but that her stomach was still hurting. When Dr McMellon asked Leila to climb onto the bed, Leila could not do so because it hurt too much. She did not even try to get onto the bed. Leila was holding her stomach at that time. This is different from what Mr Harkin said in his first statement in that there he had said that Leila had got back onto the bed. Mr Harkin's

[136] Transcript, page 404
[137] Transcript, page 420
[138] Transcript, page 422
[139] Exhibit C4a

second statement asserts that when Dr Pearton came in she adopted a' bubbly' manner when speaking to Leila. He said that Dr Pearton asked Leila if her stomach was still hurting to which Leila replied '*yes*'. She was asked to get on the bed and did so although she was hesitant. Thereafter Mr Harkin asserts in his statement that he stood and could see what was taking place. When Leila climbed onto the bed he could see a look of discomfort on Leila's face as she did so. Once on the bed she was asked by Dr Pearton to lie down, but Leila shook her head as it hurt her to do so. Mr Harkin asserts that he recalls Dr Pearton reclining the head of the bed so that Leila could sit against the inclined section. Dr Pearton appeared to be trying to cheer Leila up and he asserts in this statement that '*Leila appeared to be wrapped up with the attention and Dr Pearton's personality*'. When Dr Pearton pulled Leila's jumper up and pushed around Leila's stomach and abdomen with her fingers and asked Leila whether it hurt, Leila said '*ow, ow, ow*'. Mr Harkin could see from her face that Leila was wincing in pain. When Mr Harkin looked at the facial expressions of Dr Pearton and Dr McMellon, his impression was that they thought Leila was exaggerating. Leila was asked to get off the bed and the jump test was performed. Mr Harkin asserts that there was only the one jump which was not very high, no more than 15 centimetres. He asserts that the jump appeared to be difficult for Leila. He had seen Leila jump and skip much higher than that. He said '*Leila was caught up in Dr Pearton's personality and Leila was trying to please her because she was so bubbly and nice with kids*'. He asserts that when Dr Pearton said that Leila was free to go, Dr McMellon appeared uncomfortable with that decision.

12.10. Mr Harkin's oral evidence was in substantial accordance with what he had said in his second statement. In that oral evidence Mr Harkin colourfully described Leila's jump as one made as if she had a 20 kilogram backpack on[140]. Mr Harkin also told the Court that after discharge and on the way to the car Leila lagged about ten metres behind her parents and was holding her stomach. He and his wife attempted to provide reassurance to her, saying that the doctors have said that she was alright. Mr Harkin told the Court that when he had used the expression '*jumping around*' in his statement he had not meant that literally, but that there had just been the one jump.

12.11. In cross-examination by Mr Bonig, counsel for Dr Pearton, Mr Harkin said that at the end of Dr Pearton's examination he experienced an element of confusion due to the fact

[140] Transcript, page 625

that they were free to go but that Leila still had pain but that Dr McMellon had said that she was not going to let them go until Leila's pain had gone. This is an assertion that has a ring of truth to it. When they left Mr Harkin said to Dr McMellon words to the effect of '*what about Leila's stomach?'* to which Dr McMellon had said '*it's bruising*'[141].

12.12. Mr Harkin agreed with Mr Bonig of counsel that although Leila was not cheerful during Dr Pearton's review she had '*sparked up a bit*'[142].

12.13. The evidence of Dr McMellon and Dr Pearton painted a different picture of Leila.

12.14. In Dr McMellon's handwritten progress note[143] she recorded that at a stage prior to the backslab being placed on her wrist Leila's pain was improving. She noted as part of her plan that Leila would continue with analgesia. It appears that this a reference to the ibuprofen that was administered at 12:45am. The note then states:

> 'If pain resolves then d/c[144]'

A further note made by Dr McMellon in respect of the review, as seen above, asserts '*pain improved*'. Notably it does not assert that Leila's pain had *'resolved'*. As seen from the entry reproduced above, the resolution of Leila's pain, as distinct from its improvement, was an ingredient of the plan for discharge.

12.15. In Dr McMellon's evidence she told the Court that after Leila had been given the ibuprofen and the cast had been put on she indicated that her pain was '*much better*'[145]. Her abdomen was softer and there was no pain along the sides of the abdomen. However, when she palpated the central chest area Leila tensed her muscles up and indicated that there was pain there. Dr McMellon said that at that point she was not sure as to what the diagnosis would be and did not know what she ought to be doing, so she told the family that she could not send them home at that point and that she might have to obtain a surgical opinion. She said that Leila seemed happier and brighter at that time. Dr Mcmellon did not take any observations at that time partly because she forgot to do so and because Leila was clinically looking a lot better[146]. It was then that

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[141] Transcript, page 688
[142] Transcript, page 697
[143] Exhibit C10, page 46
[144] 'd/c' is an abbreviation for discharge
[145] Transcript, page 132
[146] Transcript, page 133

Dr McMellon decided to involve Dr Pearton. It will be recalled that in her narrative description of what Dr Pearton did during the review, Dr McMellon mentioned that Leila did have some pain towards the central aspect of her torso. Dr Mcmellon said that Leila laughed and giggled the whole time during the jumping tests and that Leila said that there was no pain when she did that.

12.16. Dr McMellon told the Court that she believed that Dr Pearton made the correct decision to discharge Leila[147].

12.17. Dr Pearton's retrospective note asserts that post analgesia Leila stated that her pain was better. Dr Pearton wrote that Leila was '*happy, alert and interactive*'. She noted that Leila did not have a rigid abdomen but had voluntary guarding only and that she was able to deeply palpate Leila without any pain. She noted the abdomen was soft with no flank pain. She noted that Leila had been able to get herself on and off the bed without pain and that she jumped without pain. There is also a note that Leila did not have a surgical abdomen and that her pain was settling.

12.18. In her witness statement Dr Pearton asserts that Dr McMellon had told her that Leila was looking better but that her pain was not completely resolved and that she thought Leila may still be tender in the abdomen and that is why Dr Pearton elected to see Leila for herself. Both Dr Pearton's retrospective note and her statement strongly suggest that Dr Pearton's impression was that analgesia had contributed to a reduction in Leila's pain.

12.19. In her oral evidence Dr Pearton said that Leila was able to move up onto the bed without any pain, that she did not appear to be in any significant abdominal discomfort or have any signs of peritonism. The only painful response exhibited by Leila was that when she went to examine Leila's abdomen and lifted her top up she had said '*ouch!*'.

12.20. In short, Dr Pearton said that she saw no clinical need to keep Leila in hospital. She said that in her opinion neither paracetamol nor ibuprofen would mask any significant abdominal pain on palpation of the abdomen, or mask any pain when someone is asked to perform the jump test[148].

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[147] Transcript, page 147
[148] Transcript, page 253

12.21. I would add that the nurse, Ms Defrancesco, told the Court that she observed Leila when she was leaving the hospital and that she looked a lot more spritely than when Ms Defrancesco had initially observed her. She said that Leila was able to walk and that she did not look like she was in pain[149].

12.22. There seems little doubt that to an extent Leila had improved both in respect of her appearance and also in respect of her own feeling of wellbeing. The underlying explanation for this would appear to be the analgesia that she had taken at the WCH. The fact that Leila apparently responded to analgesia does not shake my belief that Dr Rieger's view that Leila had peritonitis at that point in time.

13. The advice given to Mr and Mrs Harkin upon Leila's discharge from the WCH

13.1. Unfortunately there is a complete lack of contemporaneous documentation about this issue. The handwritten progress note that was prepared by Dr McMellon, which is earlier reproduced herein, and which was made at a time prior to Leila's death, simply records that the plan following Leila's review was that Leila would be discharged home with a follow up with the Ortho Clinic which of course refers to the arm fracture. Dr McMellon's eventual discharge letter[150] records essentially the same information, namely, that Leila was discharged home with her parents and that she would be seen in the Orthopaedic Fracture Clinic in a week's time. It will be observed that neither document records any diagnosis in respect of Leila's abdominal pain nor any advice that may have been tendered to Leila's parents in the event that Leila's pain did not resolve, if Leila's condition generally did not improve or if her signs and symptoms such as vomiting returned.

13.2. On the other hand, Dr Pearton's note prepared after Leila's death asserts under the heading of Plan as follows:

> Discharge in care of parents.
>
> If pain increases despite
> regular analgesia, continues
> to vomit/unable to tolerate
> fluids or if parents have
> any concerns asked to
> be R/V by GP or PED

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[149] Transcript, page 68
[150] Exhibit C10, page 65

13.3. It will be recalled that Mr Harkin gave evidence, which I accept, that Leila vomited into a bag in the car on the way back to Strathalbyn following her discharge from WCH. As well, Leila awoke with pain and vomited again at approximately 7.30am. As the morning wore on, Leila continued to complain of pain between bouts of intermittent dozing. Ultimately this prompted Mrs Harkin to make the appointment with Dr Man who saw Leila during the course of that afternoon. This appointment appeared to be counterproductive because it simply involved further misplaced reassurance being given to Mrs Harkin.

13.4. It will be seen therefore that in some senses Mrs Harkin followed the advice that Dr Pearton's retrospective note records in that Leila's continuing vomiting and pain despite analgesia prompted Mrs Harkin to seek a review by a general practitioner, although it did not occur immediately upon Leila vomiting again.

13.5. In her oral evidence Dr McMellon told the Court that during Dr Pearton's review, Dr Pearton asked Leila how she felt and whether she wanted to go home. Leila said that she did want to go home. Dr McMellon states that Dr Pearton told Mr and Mrs Harkin that she thought that the abdominal muscles had been bruised and it was this that had been causing Leila pain and that it should continue to get better. Dr McMellon said that Dr Pearton said that if Leila started to vomit again or if the pain returned or worsened, then it meant that she needed to be reviewed. Dr McMellon said that it appeared that Mr and Mrs Harkin understood all of this and that they were happy to go home at that point. This was elicited from Dr McMellon in her evidence in chief. Dr McMellon has been consistent about that issue.

13.6. In her witness statement Dr Pearton asserts that after her assessment of Leila she turned to Mr and Mrs Harkin and said words to the effect that Leila had given herself a very big jolt, that she had broken her arm, but that it would heal quite well. She asserts that she told Mr and Mrs Harkin that the pain in Leila's stomach had settled since Leila had been provided with pain relief and that *'certainly on examination of her tummy now it seems fine'*. She asserts that she said that the x-rays of Leila's chest and tummy were fine and that it was safe for her to go home but that if her pain keeps increasing despite regular pain relief, that if she started to vomit and didn't keep anything down or if they

were concerned for any other reason to please either bring Leila back to the Emergency Department or to see her GP[151]. Dr Pearton gave oral evidence to the same effect.

13.7. Mr and Mrs Harkin gave evidence that significantly differed from that of Drs McMellon and Pearton. In Mrs Harkin's original witness statement which was taken on the morning of Leila's death, she simply asserts that the reviewing doctor, whom we know to be Dr Pearton, got Leila to jump which Leila did and that the reviewing doctor had simply said *'no, she's right she can go home'*. There is nothing in that account that relates to any advice that may have been given at the time.

13.8. Mr Harkin's statement given on the morning of Leila's death states that the doctor whom we know to be Dr Pearton got Leila to do a number of tests including feeling Leila's stomach and getting Leila to jump around. Leila did not complain about the jumping but said *'ow, ow, ow'* when the doctor pressed her stomach. After these tests were done the doctor said she could go home. There is nothing in that account about what advice if any was given to Mr and Mrs Harkin about what to do if Leila started vomiting again or otherwise deteriorated.

13.9. Thus seen, Mr and Mrs Harkin's original statements made at a time when there would be very limited motive to fabricate anything that may have taken place at the WCH are neutral on the question as to what advice if any was given to them upon Leila's discharge.

13.10. In her oral evidence Mrs Harkin was adamant that all that was said after Leila performed the jump test was that Dr Pearton said words to the effect that she was 'ok to go home now'. From this, Mrs Harkin understood that Leila was safe to go home and was in a state deemed suitable to be discharged[152]. Mrs Harkin stated that she was absolutely certain that Dr Pearton did not give her any instructions as to what she should do if Leila continued to vomit or continued to have abdominal pain[153]. She said that when she left the hospital she had no understanding of the seriousness of the consequences of continued vomiting or abdominal pain and that if she had understood that the recurrence of either was symptomatic of potential internal injury, she would have insisted that Leila be kept at the hospital overnight. She said that she did not have any appreciation

[151] Exhibit C15a, page 8
[152] Transcript page 399
[153] Transcript page 401, line 22

at any time after Leila's fall that Leila's life might be in peril[154]. If she had gained an appreciation of that, she would certainly have taken Leila back to the WCH the following morning when she resumed vomiting and continued to complain of stomach pain[155]. She added also that nothing was said about a possible bowel perforation at the WCH and had no understanding of the risks that might be posed to Leila if she started vomiting or was in pain. In cross-examination by Dr Pearton's counsel, Mr Bonig, Mrs Harkin reiterated that Dr Pearton did not say anything about what she should do if Leila started to vomit or was in any other way concerned[156].

13.11. Mr Harkin also gave oral evidence about this subject. He told the Court that after Leila had jumped, Dr Pearton said that she was free to go and gestured by waving her hand in the air. I note that Mr Harkin's original statement taken on the morning of Leila's death states that the doctor, now known to be Dr Pearton, communicated especially well with Leila and was really nice to her. However, Mr Harkin said in his oral evidence that Dr Pearton did not provide any instructions to him and his wife on what to do if Leila's pain persisted. He said he was sure about that[157]. Specifically, he said he was sure that Dr Pearton did not provide any instructions about what should be done if Leila's vomiting continued. Nor did Dr McMellon tender any such advice. The only advice that Dr McMellon tendered was that in respect of a question that Mr Harkin says he asked her, *'what about the stomach'*, to which Dr McMellon had said that it was probably just bruising and that it should be okay in a couple of days. They then left[158]. In cross-examination by Dr Pearton's counsel Mr Harkin repeated that Dr Pearton did not tender any advice as to what they should do if Leila vomited again or the pain returned or worsened in which event she would need to be reviewed again[159].

13.12. I have found this issue particularly difficult to resolve. On the one hand the nature of the advice that Drs Pearton and McMellon say was given to Leila's parents would logically be given to parents in Mr and Mrs Harkin's position. There is nothing intrinsically unlikely about advice of that type being given on the discharge of a paediatric patient. The only circumstance in which advice of that nature might not be given would be if the clinicians were so confident that there would be no repetition of

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[154] Transcript pages 401-402
[155] Transcript page 402
[156] Transcript page 438
[157] Transcript page 627
[158] Transcript pages 625-626
[159] Transcript page 698

vomiting or increase in pain that they would have simply been wasting their breath in tendering that advice. Dr Pearton's account of what she said to Mr and Mrs Harkin is supported by Dr McMellon's evidence. What concerns me, however, is the fact that Dr McMellon made no note whatsoever of the advice that was given to Mr and Mrs Harkin on discharge. As well, her ultimate discharge letter makes no mention of that topic whatsoever.

13.13. On the other hand, Mrs Harkin stated in effect that if she had been tendered advice of the kind that Dr Pearton says was tendered, then she would have been concerned enough about Leila's resumption of vomiting in the morning and her complaints of pain to have returned Leila to the WCH. I do note that the advice tendered by Dr Pearton included advice to take Leila either to a general practitioner or return her to the WCH. As seen, Mrs Harkin did take Leila back to see the general practitioner. There was, as I have already observed, a delay in that process being undertaken which might be consistent with Mrs Harkin experiencing some uncertainty about what she should do when Leila appeared to be ill first thing that morning.

13.14. One would think that advice of the kind that Dr Pearton says she tendered to Mr and Mrs Harkin would be so standard and routine in these circumstances that it is intrinsically unlikely that advice of that kind was not given. On the other hand, Mr and Mrs Harkin both struck me as adults who if tendered such advice would likely have become alarmed at Leila's condition in the morning and have heeded that advice, either by way of making an immediate appointment with the general practitioner, immediately returning Leila to the Strathalbyn Hospital or even immediately returning her to the WCH. The fact that Mrs Harkin did not immediately do any of those things is consistent with her having not received advice of the kind that it is said she received.

13.15. There is one other consideration. If neither Dr McMellon nor Dr Pearton had given any advice about what Leila's parents should do if Leila's symptoms returned, it was open to Mr and Mrs Harkin to have sought that advice before they left. In saying this I do not mean to imply that they were neglectful in not doing so. That they did not seek advice smacks of the possibility that something was said to them along the lines that Drs McMellon and Pearton have suggested.

13.16. When the matter is carefully considered there remains a significant question mark in my mind as to the nature of any advice given by Dr Pearton or by Dr McMellon. I am

deeply troubled by the fact that there is not a jot of documentary evidence to support the contention that advice of the kind allegedly tendered by Dr Pearton to Leila's parents was actually provided. And I do not regard Dr Pearton's self serving ex post facto progress note as being in that category. The issue is not free from difficulty. The competing probabilities are evenly poised. I do not know where the truth lies in respect of this matter. I am not in a position to be able to make a finding as to whether or not advice of the kind that Dr Pearton said she gave Mr and Mrs Harkin was given.

14. Leila is discharged and taken home

14.1. In his oral evidence Mr Harkin recalled that Leila vomited into a bag in the car on the way home.

14.2. That night, Leila slept in her parents' bedroom. At approximately 6.30am Leila immediately complained of a sore stomach and according to Mrs Harkin looked pale and weak. At about 7.30am Leila vomited. Her vomit was watery and almost black. She declined food but sipped some water. Mrs Harkin says that she dozed on and off and that whenever she woke she would complain of stomach pain. At about 11am Mrs Harkin provided Leila with a dose of Nurofen.

14.3. At 12.04pm that day, Mrs Harkin called the Mount Barker Medical Clinic in Strathalbyn to make an appointment after becoming increasingly concerned with Leila's appearance. She continued to appear very pale and weak and continued to complain of stomach pain. An appointment was made with Dr Man for 2.15pm. I will discuss that appointment below.

15. The South Australian Trauma System - Trauma Team Activation Criteria

15.1. It is convenient to discuss this issue at this point. Tendered to the Court was the South Australian Trauma System - Trauma Team Activation Criteria[160]. The WCH Trauma Manual 15th edition dated April 2013 was also tendered[161].

15.2. The Trauma Team Activation Criteria describe the circumstances in which a trauma team should be activated. There are two levels of Trauma Team Activation, Level 1 and Level 2. Level 1 trauma and Level 2 trauma require different responses. A Level

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[160] Exhibit C16
[161] Exhibit C16a

1 response would consist of the attendance of a trauma consultant and a surgical registrar among other clinicians. A Level 2 response would consist of the attendance of a trauma consultant (in-hours only) and a paediatric registrar and radiology as requested.

15.3. I have indicated earlier in these findings that in light of the strong suggestion at the outset that Leila had fallen from a height greater than 2 metres, or 6.56 feet, Level 2 was activated. The Level 2 criteria do not appear to contain any clinical criteria, but are activated by the circumstances in which a child under the age of 16 years has been the subject of trauma. For instance, there are other circumstances that would activate a Level 2 response, such as a fall from or being kicked by a horse, or from a handlebar or other significant blunt injury to the abdomen.

15.4. On the other hand, a Level 1 response is enlivened mostly by clinical circumstances including observations of vital signs. The operative criteria include a chart that indicates that the '*normal vital sign limits*' for a child between 5 and 11 years of age are as follows: respiratory rate limits are 16-34, heart rate limits are 70-135 and the systolic blood pressure limit is 80. I understand that this figure is meant to specify a figure below which a child of that age would be regarded as hypotensive. It will therefore be understood that a Level 1 response would be activated when those vital signs were abnormal. The injury profile that would activate a Level 1 response includes, in the case of an abdominal issue, severe pain, distension and/or involuntary guarding.

15.5. Leila was assessed by Ms Defrancesco as having a respiratory rate of 36 which exceeds the vital sign limit of 34 for that parameter, a heart rate of 146 which exceeds the upper limit and a systolic blood pressure of 119. For these purposes I ignore the BP figure. Others regarded that as a normal systolic pressure. However, based on the other parameters, it appears that very early in the piece it was identified that certain of Leila's vital sign limits had been exceeded. As far as the physiological profile that would trigger a Level 1 response was concerned, clinicians are directed by the criteria to act upon the '*worst pre-hospital or on arrival status*'. The physiological triggers include an abnormal heart rate and blood pressure. Another criterion that might activate a Level 1 response is abnormal respiratory function as evidenced by '*laboured respirations*'. It will be recalled that Ms Sanders described Leila's breathing as abnormal and that her respiratory rate was in excess of the normal vital sign limit. I am not certain why the

document sets out respiratory rate limits unless it was intended to indicate that if exceeded it would trigger the Level 1 response or be regarded as an abnormal respiratory function. As far as the injury profile for a Level 1 activation is concerned there was evidence to suggest that Leila was in severe pain and had involuntary guarding, accepting as I do the evidence of the triage nurse Ms Sanders.

15.6. Naturally one does not read these types of document as one would read a statute, but it seems to me that the intent behind the Level 1 response criteria is that it should be activated when there are both abnormal vital signs as well as an abnormal clinical picture consistent with the possibility of a serious traumatic internal injury. Why in all those circumstances it could legitimately be argued that a Level 1 trauma team response was not triggered in Leila's case, or at least did not need to be considered, is difficult to comprehend. I find that a Level 1 response should have been activated no later than the time at which Ms Defrancesco took and recorded Leila's vital signs. This would have involved the attendance of a trauma consultant in due course. It ought to have attracted the early involvement of the surgical registrar at the very least. In the event no surgical expertise was brought to bear on Leila's case when the reality was that there was a surgical issue on foot.

15.7. I also observe in the WCH Trauma Manual, under '**Management Guidelines for Abdominal Injury'** under the heading '**MANAGEMENT**', that a paediatric surgery team must be consulted in all cases of suspected abdominal trauma. The document points out that in Level 1 trauma, the surgical registrar is a member of the Trauma Team. In Leila's case there was a suspicion at the outset that Leila had experienced abdominal trauma. It was only very late in the piece that suspicions were said to have been dispelled following Dr Pearton's assessment. However, it was the suspicion that existed at the outset that should have been a triggered a surgical response.

15.8. I also note from the Management Guidelines that it is stated that even minor blunt trauma to the abdominal wall in children can result in possible major intra-abdominal to hollow viscera, solid organs, blood vessels and pelvic bones. As well, it states that physical signs are often subtle and unreliable with pain and tenderness and are difficult to assess especially in the presence of an associated head injury. This document as a whole appears to prescribe a cautious approach to the diagnosis and management of suspected traumatic injuries in children.

15.9. Associate Professor John Raftos to whom I have referred, and who is an experienced and independent senior specialist in emergency medicine, suggested in the course of his evidence that the mechanism of Leila's injury together with her elevated respiratory rate and heart rate would have dictated the equivalent of a Level 1 Trauma Team Activation at other centres in Australia. In his view Leila's circumstances should also have dictated a Level 1 response at the WCH[162]. Associate Professor Raftos explained the benefits of such a response. They include surgical expertise and, as he put it, '*you get three or four heads rather than one*', meaning that there are a number of senior clinicians who can make an appropriate decision[163].

15.10. Associate Professor Raftos was also of the opinion that in the light of the significance of Leila's earlier vital sign observations, the failure to take and record further observations was not ameliorated by Dr Pearton's purported observations at the point of discharge. He said:

> 'No, this child really satisfied the criteria for a major trauma call and one of the aspects of managing critically ill, potentially critically ill patients such as this child is to take regular observations and we take observations because they're a good guide as to the wellness of a patient.'

15.11. I have examined Associate Professor Raftos' assertions that a Level 1 response, or the equivalent, would have been activated at the Sydney Children's Hospital and the Children's Health Queensland Hospital & Health Service. The Trauma Team Activation documentation for both hospitals was tendered[164]. The Sydney Children's Hospital Trauma Criteria would have been activated on the basis of Leila's rigid abdomen on presentation and by her abnormal vital signs. In that hospital a paediatric trauma team response would have consisted of the attendance of a staff specialist or emergency department Fellow, but more importantly a surgical registrar. The Sydney Children's Hospital document also states:

> 'There should be a low threshold to activate this call overnight when there are fewer Emergency Department medical staff who may be less experienced in managing Paediatric Trauma patients.'

15.12. The Queensland document describes the processes for activating a trauma call at the Lady Cilento Children's Hospital. The Trauma Team Activation Criteria are set out in

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[162] Transcript, page 1117
[163] Transcript, page 1118
[164] Exhibit C28b and C28c respectively

Appendix 1 to the document. The Trauma Attend Criteria include a significant anatomical injury and abnormal vital signs including increased respiratory rate, hypotension and increased pulse rate. Leila would arguably have met these criteria on the basis that her respiratory rate and pulse rate exceeded the limits stated in this document and on the assumption that a 'significant anatomical injury' includes both an obvious injury and a suspected injury of that nature. As with the other trauma team activation responses that have been seen in this Inquest, a Trauma Attend Team would consist of the attendance of a surgical registrar as well as other senior medical practitioners.

15.13. I am of the view that in Leila's case the Level 1 Trauma Team Activation Criteria had been met and that on that basis alone a surgical opinion should have been sought at the outset.

16. **The appointment with Dr Man**

16.1. Mrs Harkin took Leila to Dr Man's rooms at the Mount Barker Medical Clinic in Strathalbyn. The appointment occurred at about the scheduled time. According to Mrs Harkin's statement, she explained to Dr Man that Leila was still complaining of stomach pain and had vomited and that her vomit had been black. Dr Man asked if the tests undertaken at the WCH were clear to which Mrs Harkin advised that they were clear except for the fractured wrist. Leila still had her arm in the backslab. According to Mrs Harkin, Dr Man did not examine Leila's abdominal area or take any vital signs. A prescription for Painstop was given with directions for its use, including in conjunction with Nurofen. A sling was also provided for Leila's backslab.

16.2. At this point, Leila undoubtedly was suffering from peritonitis and I so find. Dr Man's witness statement deals with this appointment.

16.3. Dr Man's consultation notes for this appointment records that on the previous day, Leila had been sent to the WCH for further assessment. The result of that hospital attendance was recorded by Dr Man as follows:

> 'Had scans etc, ruled out internal bleeding, has fracture L forearm?'

As to Leila's presentation, Dr Man recorded:

> 'In pain, has only had Nurofen.'

16.4. In her original witness statement dated 4 December 2015[165], Dr Man states that at this appointment the gist of what Leila's mother told her was that the WCH had performed 'scans' on Leila after which she had been discharged. Since her discharge, Leila had stomach pain and was still vomiting. She asked Leila's mother whether she had been given anything at the WCH for Leila's treatment or had been given a letter. She was told that nothing had been given. It is correct that no discharge letter had been provided. According to Dr Man's statement she asked Mrs Harkin what type of scans had been performed on Leila and that Mrs Harkin had said that she was not sure. I observe that Dr Man recorded that her information was that Leila had undergone scans and so I think it is probable that Mrs Harkin did use that word. There was some further conversation about what Leila had taken by way of pain relief since the WCH and also about the arm injury. Leila's mother said that the doctors who had seen Leila at the WCH had '*ruled out any internal bleeding*'. This would account for the reference to bleeding in Dr Man's note. I accept that words to this effect were said.

16.5. Dr Man's statement asserts as follows:

> 'I assumed that Leila had been thoroughly examined and assessed at the WCH and was reassured that no serious condition had been identified.'

16.6. Dr Man's statement asserts that she explained to Leila's mother that Leila had fallen from the equipment from a height of one storey and that even if she had not broken or injured anything other than her wrist she would still be in pain. Dr Man felt that Leila had so far been given insufficient pain relief and so she prescribed the Painstop which contains both paracetamol and codeine. Instructions were given to Mrs Harkin regarding the frequency of dosage.

16.7. Dr Man acknowledges in this statement that she did not physically examine Leila. She did say that at the consultation Leila looked '*quite uncomfortable and in pain*', but that she did not look acutely unwell. Leila was conscious, talking and walking. As far as the pain was concerned, she asserted that Leila seemed '*somewhat annoyed*' at how much pain she was in.

16.8. Dr Man's statement describes how on Thursday 1 October 2015 she was told of Leila's death and how shocked and upset she was to learn of this. The final section of Dr Man's statement contains reflections on the 30 September 2015 consultation with Leila and

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[165] Exhibit C17

her mother and on the shortcomings in her management of Leila. The principal concession made by Dr Man is that she should have physically examined Leila's abdomen. Dr Man's statement goes on to say that a physical examination would probably have elicited significant pain and therefore may have prompted Dr Man to seek a review from a more senior medical practitioner and/or to have sent Leila for CT imaging or even to have sent Leila back to the WCH. Dr Man further acknowledges that she could have phoned the WCH to enquire about the nature of investigations and of the assessment that had been undertaken and to seek further advice.

16.9. One matter that is of some importance is Dr Man's reflection that she would now be much less assured by a patient being recently seen and discharged by a tertiary hospital such as the WCH.

16.10. Dr Man gave oral evidence in the Inquest. Dr Man is a general practitioner who obtained her basic medical degrees in 2009. She had experience and training within the Modbury Hospital Emergency Department where she was a resident medical officer. She saw trauma patients in that capacity but they did not include paediatric trauma patients. She was awarded her Fellowship of the Royal Australian College of General Practitioners in 2015.

16.11. In this section of the Court's finding I confine my discussion to Dr Man's management of Leila at the appointment on the afternoon of Wednesday 30 September 2015. In her oral evidence Dr Man explained that she did not contact the WCH that day as she believed that she had asked Mrs Harkin enough questions about what had happened the night before. Her assumption had been that her original principal concern of intra-abdominal pathology had been ruled out. She explained that she was of the belief that they had performed scans that had ruled out any intra-abdominal pathology[166]. She was asked about the type of imaging modalities or scans that she believed would have been undertaken, and she said '*I would have expected a chest x-ray, abdominal x-ray and an ultrasound*'[167]. It will be noted there that in that answer Dr Man did not include CT imaging. Certainly a chest x-ray and abdominal x-ray had been performed but no ultrasound had been performed.

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[166] Transcript page 329

[167] Transcript page 330, lines 12 and 13

16.12. However, in another section of her evidence Dr Man seemed to suggest that she would have had an expectation that a CT scan would have been administered to Leila when she originally referred her to the WCH. As will be seen a CT scan is a diagnostic modality of greater significance in these types of scenarios. She told Dr Pearton's counsel, Mr Bonig, that when she sent Leila to the WCH she thought that they would have provided pain relief, give her something to stop her from vomiting and would perform a trauma assessment and possibly admit Leila. Asked as to why they would admit Leila she believed that they would do so in order to further observe Leila, to control her pain and to have '*scans done*'[168]. Asked as to what she meant by scans Dr Man said '*an ultrasound, a CT or even an x-ray*'[169]. However, she then clarified that by stating that when Leila's mother had mentioned scans she assumed that it had been a reference to x-rays and an ultrasound only. In the event, I did not understand Dr Man to be saying that she believed that Leila had undergone a CT scan. Naturally, any reassurance that would have been derived from the belief that a CT scan had been undertaken would have been greater than if x-rays and an ultrasound had been undertaken. Also, Dr Man's assertions that she would have contemplated sending Leila to Mount Barker for a CT scan depending on the results of a physical examination tends to suggest that she had no such belief at the time she assessed Leila on the afternoon of 30 September 2015. In any event, it would have been unreasonable for Dr Man to have concluded that Leila had undergone a CT scan because that could easily have been established either by contacting the WCH or by asking Mrs Harkin a few simple questions including whether or not Leila had been placed in the 'tunnel' environment that a CT scan utilises.

16.13. We know that Leila was not administered with any ultrasound imaging at the WCH. Again, it would not seem reasonable for Dr Man to make any assumption about whether an ultrasound had been administered without making the necessary enquiry of the WCH or asking Mrs Harkin questions that would have revealed whether or not the known characteristics of an ultrasound examination had been evident in Leila's examination at the WCH.

16.14. As far as x-rays are concerned, Dr Man told the Court that she was aware that an x-ray might assist in the diagnosis of a perforated small bowel in that it may show free air

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[168] Transcript page 345, line 10
[169] Transcript page 345, line 13

under the diaphragm, but she acknowledged that this would not exclude a bowel perforation[170]. On the other hand, she stated that if the x-ray had been negative, she would have believed that an ultrasound would have picked up free fluid which would have indicated some form of intra-abdominal pathology that would need to be investigated. To my mind, however, for the reasons already given, without further enquiry it would not have been reasonable for Dr Man to have assumed that an ultrasound was administered.

16.15. The issue of Dr Man's belief as to whether an ultrasound had been undertaken appears to have assumed some importance in Dr Man's mind. She was asked by counsel assisting, Ms Kereru, as to what she would have done if she had realised that the only imaging that had taken place had been x-rays. Dr Man told the Court that she would have called the WCH and have asked to speak to a consultant and questioned whether their protocols recognised the value of ultrasound. She then went on to explain that if the response had been along the lines that the child had been well enough to be discharged and had been discharged without ultrasound, Dr Man would have asked if they could review her again and immediately would have sent her down to Adelaide for that purpose by private transport[171]. It was thus important for Dr Man to have contacted the WCH for two reasons, namely, to query whether an ultrasound had been administered, but secondly, it would have enlightened Dr Man about the nature of the examination that had taken place there and likely would have prompted Dr Man to instigate a further review.

16.16. Interestingly, Dr Man was of a view that Leila's case would have been one of those cases where one would unhesitatingly send a child for a CT scan notwithstanding concerns about radiation, a commonly voiced objection to the needless administration of CT scans to children[172].

16.17. In addition to the issue of scans, Dr Man also told the Court that the circumstances in which Leila had been seen at the WCH, including the fact that she had been seen and discharged in the early hours of the morning, also provided some reassurance to her. She surmised that if staff at the WCH had entertained any reservations about Leila in terms of abdominal pathology she would have been admitted[173]. I believe that what

[170] Transcript page 345, line 25
[171] Transcript page 360
[172] Transcript page 349
[173] Transcript page 331, line 10

Dr Man was saying here was that given the time of the morning at which Leila was discharged, it would have been simpler to have admitted Leila for observation and that this had caused Dr Man to believe that a heightened degree of satisfaction that Leila did not have any serious internal injury had been entertained at the WCH. One can see the force in that, but one would still need to have known precisely what the WCH actually did in order to have come to such a high degree of satisfaction. To my mind such a level of satisfaction could not be assumed.

16.18. It will be recalled that when Leila was discharged there was no discharge letter compiled at the time. Ultimately a letter was compiled by Dr McMellon[174]. The only diagnosis recorded in the letter was a fractured lower end radius/ulna. The narrative in the letter goes on to explain Leila's presentation with abdominal pain and arm pain following a fall in which she had jumped off a swing landing on her hands and her abdomen. It also states that examination and x-ray demonstrated a fracture of the distal radius but no other injuries. Dr Man was asked in her evidence about that discharge letter and its potential impetus in her own assessment of Leila. The first time she had seen the letter was on the day that she gave evidence in the witness box. Having read the letter in the witness box for the first time, Dr Man stated that she would have been less reassured about Leila and her discharge from the WCH if she had seen the letter on the afternoon of 30 September 2015. Asked as to why that would be the case, she said '*it doesn't say anything really about the abdomen and what investigation was done for that*'[175]. This, she said, would have prompted her to enquire as to what had been done in respect of examination of the abdomen and to enquire as to the type of scans that had actually been administered. If she had not obtained a clear answer she would have spoken to the consultant at the WCH. If having read the letter she had come to the belief that only x-rays had been administered, she would have assumed that internal injury had been ruled out on clinical grounds alone. In that event she would have wanted to know what those grounds had been because it would have given her an idea as to what the person who saw Leila had thought. All of this doubt, together with information that only x-rays had been undertaken, would have prompted her to seek a further review at the WCH and to send Leila down to Adelaide for that purpose.

[174] Exhibit C10, page 65
[175] Transcript page 354, lines 14 and 15

16.19. Much of Dr Man's management of Leila turned on her failure to conduct a physical examination on Leila's abdomen. Further, there was no taking of vital signs such as temperature, heart rate and respiratory rate, although Dr Man believed that clinically Leila did not look particularly unwell. Yet, in reality Leila was in no better condition than she had been the night before. I am sure that Dr Man's acknowledgement that she should have physically examined Leila is in some measure appreciated. The failure to do so is somewhat explained by Dr Man's state of reassurance that she believed was due to the fact that the WCH had discharged Leila, but this is perhaps no more than an understandable state of mind on Dr Man's part. It mitigates Dr Man's performance but it does not excuse it.

16.20. Counsel assisting, Ms Kereru, asked Dr Rieger to comment on whether Dr Man's assessment was appropriate or not. Dr Rieger responded by suggesting that the expectation would have been that an examination would be appropriate given the nature of Leila's complaint. He notes Dr Man's own acknowledgement that she should have conducted an examination, and so Dr Rieger suggested that the assessment at that time was not adequate[176]. As to whether it was reasonable for Dr Man to have relied on the knowledge that Leila was seen at the WCH and released without a follow-up plan, Dr Rieger said that Dr Man might appropriately have asked questions about the nature of scans, for example, to establish what had taken place[177]. Dr Rieger also agreed with Dr Man's assertions that had she examined Leila's abdomen, it is likely that it would have yielded some significant findings.

16.21. In cross-examination by Mr Harris QC, counsel for Dr Man, Dr Rieger agreed with the proposition that unless intra-abdominal organ damage including a perforation had been definitively excluded at the WCH, Leila should not have been sent home. Asked by Mr Harris QC about the reasonableness of an assumption on Dr Man's part that any question of intra-abdominal organ pathology had been excluded by whatever had taken place at the WCH the night before, Dr Rieger agreed that this would be a '*fair assumption*'[178]. In fact Dr Rieger said this:

> 'I think it's a fair assumption, so at this point in time, Dr Man has a review of Leila and knows that she's been to the Women's and Children's and knows that she's been discharged, knows that she's had an x-ray, she doesn't have a discharge summary, she has a verbal history from the mother, Edith Harkin and it's of her belief that she's had - I would assume

176 Transcript, page 487
177 Transcript, page 488
178 Transcript, page 532

> and I think it's reasonable to assume, that she believes that significant injury has been excluded. '

16.22. Dr Rieger added that in the setting of a country hospital he did not think it unreasonable for a general practitioner to assume that based on the fact that the hospital had sent the patient home, an abdominal injury had been excluded.

16.23. Associate Professor Raftos was also asked to express an opinion in respect of Dr Man's management. He stated that he would have expected the doctor to at least examine the abdomen and to take the child's pulse[179]. He added this:

> 'Well, I'd say two things. I'd say the Swiss cheese theory first. An initial error frequently leads to further error and it would be reasonable I would have thought for a doctor to think that the patient has been to a reasonably prestigious hospital found to not have any problem. That would colour your thinking. So that's the first thing I'd say. The second thing that I would say was certainly if knowing the history of the child and what had happened and that the child had vomited again then the doctor needed to revisit at least the pulse rate and the examination of the abdomen.'

16.24. Dr Craven gave some brief evidence about this issue in response to Mr Harris QC's questions. Mr Harris QC tackled Dr Craven about the reasonableness of a belief on Dr Man's part that intra-abdominal organ pathology had been excluded by a tertiary referral hospital, to which Dr Craven said '*I think it's a very dangerous belief as is shown in this case*'[180].

16.25. I have accepted Dr Man's evidence as to her state of mind during her consultation with Leila on the afternoon of 30 September 2015. To my mind there is no doubt that Dr Man should physically have examined Leila and have taken her vital signs. Dr Man's assumption that Leila had been fully cleared of a serious injury at the WCH was understandable but unfortunately unwarranted.

17. <u>The evidence of Dr Rieger concerning Leila's management</u>

17.1. I have dealt elsewhere with Dr Rieger's opinion concerning the origin, nature and timing of Leila's injury. In this section I will deal with Dr Rieger's opinions as to what Leila's presentation at the WCH could or should have signified as far as possible

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[179] Transcript, page 1143
[180] Transcript, page 727

diagnosis is concerned and also his opinions as to the appropriate course of action that medical practitioners may have taken.

17.2. I take into account that Dr Rieger is not an emergency physician but is a colorectal surgeon viewing the matter from the perspective of a medical practitioner of that kind. To my mind, however, Dr Rieger's opinions are to be accorded significant weight, remembering of course that Leila's was potentially a surgical presentation at the WCH.

17.3. In his report Dr Rieger recites Leila's history as he understood it to be from the clinical notes made by Dr Man and from those made at the WCH. He specifically notes that Leila had a temperature of 38 degrees but that Dr McMellon's notes describe Leila as having been afebrile when that was not in fact the case. It appears from Dr Rieger's report that at the time of its preparation he did not have access to Dr Pearton's retrospective notes nor to her statement. He does recite Dr McMellon's notations regarding the final review including the reference to there being no signs of peritonitis and that the abdomen was soft whereas before it had been described as rigid. Dr Rieger also notes that Dr McMellon recorded that at the time of the final review Leila's pain had improved. On the other hand Dr Rieger's report also observes that based on the statements of Mr and Mrs Harkin it appears that Leila was discharged home still with pain in the abdomen. This prompted Dr Rieger to opine that because the pain had not resolved and because there had been findings of significance such as the high temperature, the rigidity on examination and the high pulse rate, further investigation could be seen as appropriate. The further investigation was not undertaken at that point and another course of action would have been for further observation to be maintained within the hospital in order to assess the pain over time and to reassess the abdomen at a later time and then to decide if further investigations were appropriate. In his report Dr Rieger repeats that it may have been more appropriate for Leila to have been the subject of continued observation at the hospital and to have been further assessed after a period of time. As to the duration of that period Dr Rieger suggested that an appropriate time would be until the symptoms had resolved. If there was still persisting pain in the morning or relevant abdominal findings, an appropriate investigation or opinion would have been obtained. Dr Rieger expresses the view that because of the continued abdominal symptoms and signs that Leila displayed, it is likely that a small bowel perforation would have been diagnosed after observation. Dr Rieger then suggests that appropriate surgery could have been undertaken following diagnosis and

that the surgery would have consisted of a laparotomy and repair to the small bowel injury. He suggested that if such an operation had been performed within 12-24 hours after Leila's presentation to the WCH, her prognosis would have been excellent. He believed that Leila's death was preventable in that the small bowel injury if diagnosed would have been treatable. I expand on this aspect of the matter below.

17.4. Dr Rieger expressed a number of opinions about Leila's presentation. He regarded Leila's pulse rate of 146 as very high. He regarded her temperature of 38 as a high temperature. Asked as to whether he would describe it as mildly elevated as others had described it he replied that in his view it was a significant temperature in the setting of Leila's overall presentation.

17.5. Dr Rieger also noted that Leila's heart rate had persisted from Strathalbyn and if anything had become worse once at the WCH. Added to that was her fast rate of breathing which in his view indicated *'she's got a significant problem'*[181].

17.6. Dr Rieger did not believe that bruising to the abdominal wall would have explained her presentation. He did not believe that this would cause the high temperature or high pulse rate. He said if one was distressed with the pain then there may be a subtly high pulse rate, but not 146 with a respiratory rate which he said was very fast and rapid breathing[182]. To sum up he said '*It just doesn't fit. So bruising, no*[183]'.

17.7. It will be remembered that both Dr McMellon and Dr Pearton assert that they mistook the temperature and viewed Leila as afebrile. To this Dr Rieger suggested that regardless of whether Leila was afebrile or not the other findings were abnormal in a person who had experienced trauma to the abdomen. However, the raised temperature of 38 would have made the picture more robust which he added was *'adequately robust in any case'*[184].

17.8. Dr Rieger dealt with the question regarding voluntary guarding against involuntary guarding. Dr Rieger said that whether guarding was voluntary or involuntary can be difficult at times to work out, and at other times impossible and that it is a very subjective way of examining things. Dr Rieger viewed the matter in this way, that the important facet of Leila's presentation was that there was guarding and that the muscles

[181] Transcript, page 460
[182] Transcript, page 460
[183] Transcript, page 460
[184] Transcript, page 462

were contracted as a protection mechanism for whatever was going on inside Leila's abdomen[185]. Dr Rieger also added that involuntary guarding as a result of an internal abdominal injury could possibly fluctuate such that the level of pain that would be elicited on examination might have variable levels[186].

17.9. Dr Rieger agreed that abdominal x-ray cannot be relied on to definitively rule out such an injury[187]. That much appears to be common ground. He did say, however, that it would be reasonable to perform an x-ray in the first instance because if it had shown free gas then it would indicate that there was a perforation, but that the gold standard for further investigation would be the CT scan. Again there does not appear to be any dispute about that.

17.10. As to the evidence that later in the piece Leila appeared to be or was feeling better, Dr Rieger referred to the administration of Panadol at 11:57pm as potentially improving Leila's temperature. This could result in a person feeling less unwell and could also have assisted with the pain.

17.11. There seemed little doubt in my opinion that the Panadol at 11:57pm and the Nurofen at 12:45am would have had some positive affect on Leila. If it reduced Leila's feeling of unwellness or reduced her pain then it would be hardly surprising in a child of the age of 9 that she would have derived some personal assurance from it and that her mood would reflect this. Of course, this would not alter the nature of her original presentation.

17.12. Dr Rieger acknowledged that the critical question in the whole of the case was whether it was appropriate to discharge Leila at approximately 1:30am on the morning of 30 September 2015. Dr Rieger said:

> 'That's the critical question of this whole Court case I think. Trying to not know what then subsequently happened and based on the degree of tenderness that's elicited with rigidity, the observations that are observed with a high fever, a rapid pulse rate and a rapid respiratory rate and given the history with the height of the fall, I think you could argue, strongly, that it was inappropriate to send her home. I mean, that's an argument and that's an opinion.'

Dr Rieger added that the various pathways, such as a CT scan, that could have been taken at that time may not have been immediately appropriate in the light of the easing

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[185] Transcript, page 463
[186] Transcript, page 492
[187] Transcript, page 464

of her symptoms, but he believed that observation of Leila would have been the appropriate thing to undertake. Dr Rieger expressed the view that one would then have seen the evolvement of her situation and have seen how clinically Leila progressed. Ultimately further investigations would have been done. Asked to what might have evolved if Leila had been observed, Dr Rieger said that he believed one would have seen a continuation of abnormal observations, observations that would have been very much out of keeping with someone who was well. What would also have been seen was a need for continuing analgesia and pain relief. He said that after further observation it would have become obvious that Leila was not well. The clinical evidence would have consisted of ongoing pain and/or further abnormality of her pulse, blood pressure and respiratory rate all of which would have been further monitored[188]. On the question of vomiting, and as to whether continued vomiting would have been of diagnostic significance, Dr Rieger believed that this would have informed clinicians that they had a sick child on their hands[189].

17.13. Asked as to the significance of the matters recorded by Dr Pearton in her retrospective note, including her assessment of Leila's clinical picture as well as the asserted normal heart rate and respiratory rate, on the basis of what she had recorded, Dr Rieger agreed that one would send Leila home[190]. However, as seen earlier, Dr Rieger believed that certain aspects of that picture represented a vast improvement on what the original observations had been and that it was out of keeping with other documented information. His opinion, which I accept, was that the small bowel did have a perforation in it and so Dr Pearton's purported observations did not gel. Dr Rieger did say that having regard to the earlier observations which were distinctly abnormal, a further set of observations would have been appropriate. If such a set of observations had been abnormal there would have been no comfort to be derived from them and the appropriate cause of action would have been to observe the child or further investigate.

17.14. Dr Rieger also dealt with the information as contained in Dr Man's referral letter. He said that there were several factors in the letter that concerned him. They included the height from which Leila had fallen which he regarded as a significant height, the fact that the letter appeared to state that the abdomen was directly injured and the description of the pattern of vomiting together with the difficulty that Dr Man had experienced in

[188] Transcript, page 475
[189] Transcript, page 476
[190] Transcript, page 482

examining Leila as a result of the at vomiting[191]. Dr Rieger agreed with cross-examining counsel that without taking one's own history, the letter would not lead one down the pathway of a diagnosis, but he suggested that it would lead one down a pathway whereby a conclusion could be drawn that a significant event in respect of Leila had occurred and that while in the first instance this would not necessarily require further investigation, it would dictate a need for further assessment and evaluation which might ultimately include diagnostic investigations[192].

17.15. In cross-examination by Mr Bonig, counsel for Dr Pearton, Dr Rieger was asked to consider Leila's initial presentation, particularly as evidenced in the notes recorded by Dr McMellon. Dr Rieiger referrd to the picture of Leila's abdomen that Dr McMellon drew in her notes. As a surgeon Dr Rieger stated that the picture drawn by Dr McMellon, indicating as it did tenderness all over the abdomen, is something that a surgeon draws all of the time. When accompanied by a description of rigidity it makes him, as a surgeon, immediately think that something is wrong in the abdomen. He added that in Dr McMellon's notes there were a number of *'red flags'* indicating that something was not right with Leila. Even excluding the incorrect temperature, *'that just looks to me like there's a significant injury within the abdomen[193]'*. Therefore, examining all of those matters in context, he said *'to be honest, you'd be sticking an IV in, getting some bloods and ringing for an x-ray which may at this point in time, if you really want to push me hard here, a CT scan, looking at that page'*[194].

17.16. In cross-examination by Mr Harris QC for Dr Man, Dr Rieger dealt with the proposition that Leila's presentation may reasonably have been viewed a relatively benign reflection of muscular and soft tissue damage to the abdominal wall. To this Dr Rieger stated that if that had been the case, the expectation would have been that Leila's condition would have progressively improved over time with adequate pain relief and added that such a presentation would not be associated with the other features of illness. By saying this I took Dr Rieger to be disagreeing with the proposition that Leila's presentation was consistent with soft tissue damage to the abdominal wall.

[191] Transcript, page 495
[192] Transcript, page 496
[193] Transcript, page 499
[194] Transcript, page 499

17.17. In a sense Dr Rieger's opinion about Leila's discharge is summed up in this question and answer as elicited by Mr Harris QC:

> 'Q. Would you agree with this proposition, that unless you can exclude, that is, definitively exclude intra-abdominal organ damage including a perforation at the Women's and Children's Hospital on that night by whatever means, she shouldn't be sent home.
>
> A. Yes.'

17.18. I later deal with Dr Rieger's evidence about Leila's prospects of surviving this injury if timely diagnosis and surgical intervention had been provided to her.

18. <u>**The Evidence of Associate Professor Raftos**</u>

18.1. I have already referred to Associate Professor Raftos' evidence in another context, including his view that the Level 1 Trauma Protocol should have been activated.

18.2. In his report, Associate Professor Raftos explains the course of action that would have been expected to occur if an assessment had been made by a Surgical Registrar as part of a trauma team as should have been the case here. Firstly, the Registrar would have taken the history of a fall from about 10 feet onto the abdomen followed by persistent abdominal pain and vomiting. The Registrar would have found that Leila's abdomen was tender and rigid. The appropriate response to such presentation would have been to suspect serious intra-abdominal injury and to perform a FAST ultrasound scan. If the FAST scan was positive, Leila should have been taken to the operating theatre for laparoscopy/laparotomy. If the FAST scan was negative an abdominal CT should have been performed. On the balance of probabilities a CT scan would have shown the presence of free intra-peritoneal gas indicating rupture or perforation of a hollow viscus such as the bowel. Associate Professor Raftos opined that this finding would have led to an urgent operation in which the perforation in Leila's bowel would have been discovered and appropriately treated in which case, on the balance of probability, she would have recovered from her injuries.

18.3. Associate Professor Raftos' report also asserts that the abnormally elevated vital signs recorded when Leila first presented suggested the possibility of serious illness or injury. Given their abnormality, he asserted that the hospital is obliged to conduct further observations to determine whether they remained in the range suggesting serious illness or injury or returned to normal. The failure to do so represented, in his view, a departure

from widely accepted peer professional opinion and from an acceptable standard of care. On the assumption that Dr Pearton had performed some observations before Leila was discharged, they should have been recorded on the observation chart. Dr Pearton's failure to record those observations represented a departure from widely accepted peer professional opinion and a departure from an acceptable standard of care.

18.4. Associate Professor Raftos' report asserts that the jump test had no validity in determining whether a child has an internal injury or peritonitis. He surmises that Dr Pearton performed the jump test because she thought that Leila may have peritonitis or an intra-abdominal injury. However, Associate Professor Raftos asserts that the appropriate response to the suspicion of peritonitis would have been to ask the Surgical Registrar to assess Leila and to perform an abdominal CT scan.

18.5. In his report Associate Professor Raftos is also critical of the failure of the doctors in the Emergency Department to read Dr Man's referral letter which he also regards as a departure from an acceptable standard of care.

18.6. In his report Associate Professor Raftos asserts that given that Leila had an elevated heart rate, abdominal pain and a rigid abdomen following a fall from a substantial height she should have been admitted to hospital for observation under the care of the surgeon on call. If she continued to vomit or her abdominal pain persisted, an abdominal CT scan should have been performed. I note that this is almost identical to the approach that was advocated by Dr Rieger and by Dr Sebben.

18.7. As to the significance of Leila's improvement and whether that was a reliable indicator that she did not need further assessment, Associate Professor Raftos pointed to Leila's history of persistent vomiting, elevated heart rate, tender and rigid abdomen and a fever following a fall from a substantial height and added '*whether or not her condition temporarily improved, the only appropriate course of action would have been to obtain surgical review and admit her to hospital for observation*'[195].

18.8. In his oral evidence, Associate Professor Raftos repeated many of the observations that were contained in his report. He emphasised on a number of occasions that Leila had pain in her abdomen and had an injury to her abdomen but that the cause of the pain had not been determined. Therefore, she needed to be admitted to the hospital in order

[195] Exhibit C28, paragraph 15

to determine the cause. The fact that the pain altered in strength or had changed, had become more fixed in relation to its location and was not across the whole of the abdomen should not have affected the decision to admit or not as Leila still had abdominal pain and the doctors had not determined the cause of it. Therefore, it was not appropriate to send her home[196]. Associate Professor Raftos asserted that if a person was administered with analgesia, it would be possible for a rigid abdomen to subsequently soften even with peritonitis[197]. Similarly, there was limited relevance to Leila's not vomiting at the WCH. according to Associate Professor Raftos the fact that she had vomited is more relevant[198] and that it was important for the hospital to have determined that Leila would no longer vomit. The fact that she did not vomit during the two hours that she was at the WCH was not significant to her diagnosis. The fact that she vomited approximately ten times beforehand was more significant to the diagnosis. He said '*the fact that she had stopped vomiting doesn't mean anything in particular*'[199].

18.9. Associate Professor Raftos also repeated the need for monitoring and the undertaking of observations. However, he emphasised that the initial observations of elevated heart rate and other elevated parameters along with the complaint of abdominal pain and generalised abdominal tenderness had required that Leila be admitted to hospital in order to determine what the cause of those things was[200].

18.10. On many occasions Associate Professor Raftos repeated that there was a need for admission for Leila and suggested that his opinions were not predicated simply on the basis of an elevated heart rate, but were based on that together with the initial respiratory rate, the vomiting and the diffuse tenderness. As to the Dr Pearton's purported observations of a heart rate of 100 and respiratory rate of 20 prior to discharge, Associate Professor Raftos pointed out that the earlier observations had suggested that Leila had suffered a serious illness. In this context, when evaluating the child's presentation at 1am and in assessing whether the features of her earlier presentation could be ignored, Associate Professor Raftos said that they could not be ignored. He said as follows:

> 'Because those features suggested that she'd suffered a serious illness. The fact that her vital signs have come back to the normal range after she has been given some analgesia

[196] Transcript pages 1126-1127
[197] Transcript page 1159, line 17
[198] Transcript page 1165, line 14
[199] Transcript page 1135, line 27-28
[200] Transcript page 1127

> shouldn't be that reassuring, because the cause of the initial vital signs and the tenderness and guarding of her abdomen hasn't been elicited - elucidated, sorry.' [201]

18.11. So even if one were to accept that Dr Pearton took those observations at the end, their significance was diminished by the analgesia that Leila had taken in any event.

18.12. Both in his report and his evidence, Associate Professor Raftos made some further observations about the likelihood of Leila surviving if appropriate surgical intervention had been provided to her. I mention those observations below.

19. <u>The Evidence of Dr John Craven</u>

19.1. Dr Craven provided two reports to the Inquest through Dr Pearton's counsel and instructing solicitor. The first report is dated 3 January 2016. Dr Craven also gave oral evidence following the provision of that report[202]. Following the provision of Associate Professor Raftos' written report by counsel for Mr and Mrs Harkin, a further report was submitted from Dr Craven. That report is dated 16 November 2016[203]. Following the provision of all of those reports, Associate Professor Raftos gave his evidence in December 2016.

19.2. The salient features of Dr Craven's first report are as follows. I add my own commentary where necessary:

- A rigid abdomen refers to involuntary guarding. There is no dispute about that. He distinguishes voluntary guarding which he suggests can be subtle and can benefit from analgesic administration. He asserts that he does not support the view that involuntary guarding might respond to analgesia.
- The absence of gas on an apparently normal x-ray film does not rule out significant abdominal injury. Again, there is no dispute about this.
- Dr Craven asserts that FAST scans were developed specifically to look for free fluid in the abdominal cavity of an unstable adult trauma patient. He suggests there are significant issues with its validity in children. He suggests that its utility is highly dependent on the skill of the user and the amount of fluid present. He agrees that it is thought that 300ml of free fluid is the minimal amount required to be detectable on FAST scanning. He suggests that in the case of a child this quantity would

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[201] Transcript page 1182, lines 8-14
[202] Exhibit C24a
[203] Exhibit C24b

represent more than 15% of blood loss which of course is a significant amount. This is beside the point in many ways. The possible detection of blood loss is but one possible fluid loss into the abdomen. The suggestion in this case is that the free fluid would be fluid lost from the ruptured bowel. As indicated by the radiologist Dr Sebben, there may or may not be that quantity lost from the bowel, but it will also be remembered that Dr Sebben was advocating serial FAST scans over a period of time during which the patient is observed. That is the utility that was being spoken of, not the detection of acute blood loss.

- Dr Craven asserts that the jump test is one of several ways to elicit signs of peritonitis.
- In response to a question posed in the report as to whether it was relevant that Leila was examined by Dr Pearton some 12 hours after she had fallen from the swing, Dr Craven asserts that all evidence and medical teaching emphasises that signs of abdominal pathology develop over time and encourages repeated observation and examination. He suggests that it would be prudent and common practice for children to be observed for a period of time (4 hours is traditional but has no evidence base) after certain injuries such as head or abdominal trauma. Examining a child 10-12 hours post incident would be somewhat reassuring if one could find no signs of significant injury. It will be noted that Dr Craven speaks of repeated observation and examination. Within the two hours approximately that Leila was in the WCH emergency department there appears to be little evidence of repeated observation and examination. I do not accept Dr Pearton's evidence that she took Leila's vital signs at the end, and in any event, her temperature was never re-taken.
- In his report Dr Craven asserts that it is unlikely that he would have performed a CT scan based on the examination findings. A CT would be indicated if he had been concerned about significant abdominal trauma. I would observe that if one was concerned about such trauma, one would likely regard those concerns as tipping the balance in favour of exposure of radiation. However, Dr Craven correctly identifies that the real question was whether Leila should have been admitted overnight for observation. All other experts in this case suggest that this would have been the appropriate course having regard to the significant findings at the time of Leila's initial presentation at the WCH. In his report Dr Craven suggests that decisions to admit for observation or not are usually based on peripheral data such as distance from hospital to home, family dynamics, time of day, time from

injury and overall concern. He suggested that if there are no significant findings, discharge or observation are indicated. So if there are signs of significant abdominal pathology, a CT scan or surgical admission is indicated. The point would need to be made that if a decision is based upon the matters that he identifies such as distance from hospital to home and the time of day, surely this would have militated in favour of keeping Leila at the hospital. As well, on anyone's version there were significant findings at the outset including the rigid abdomen, the raised temperature which was hopelessly misread or misinterpreted and the other raised vital signs.

- Within the report the question was posed to Dr Craven whether on the basis of the information available to Dr Pearton at the completion of her examination, Dr Craven himself would have discharged Leila or kept her for further observation. He suggested that he probably would have discharged her home although he may have kept her for observation. He said there were certain reassuring factors such as a lack of signs of significant abdominal injury, the negative x-ray findings, hunger, and the duration of time since the incident. I have found that Leila was not hungry, she did not eat the biscuits that she was given. As well, I do not accept that Dr Pearton took Leila's vital signs, and in any event I prefer Associate Professor Raftos' evidence that one would need to have greater regard to the signs and symptoms that Leila displayed on her arrival at the Hospital. Dr Craven acknowledges that balanced against reassuring factors in this case were concerning factors such as the time of the day and the distance to Leila's home as well as the initial observations. To my mind the balance was clearly in favour of admission when all of those matters are taken into consideration. I prefer the evidence of Associate Professor Raftos because it makes more sense and observation would clearly have been the cautious course to have taken. Indeed, some might say that not to have admitted Leila had an element of recklessness about it.

- Asked as to the significance that the misreading or misinterpretation of Leila's temperature may have been in Leila's case, Dr Craven begins by suggesting that the temperature of 38C is out of keeping with the rest of the presentation. I am not certain what is meant by that unless he is suggesting perhaps that the temperature may have been incorrectly taken. He suggests that temperature should have been repeated. Ms DeFrancesco told the Court that the figure of 38 was not a rounded up figure. She said it was a figure that was precise. No other entity suggested

during the course of this Inquest that the temperature may have been taken in error. In the absence of any further evidence about temperature, the clinicians in Leila's case could have acted on no basis other than that the temperature was 38. Dr Craven makes the valid point that if the temperature had been retaken and it had been found to be correct, and a cause explaining it could not be found, it would be one more factor that would lean him towards further investigation or observation. I agree with this approach. On that basis the elevated temperature ought to have clinched Leila's being kept in the hospital for observation. The temperature of 38 was hardly out of keeping with the rest of Leila's presentation. Indeed it was very much in keeping with Leila's initial presentation and with the suggestion that she may have suffered a serious internal injury. The raised temperature was at no stage given proper consideration. There is no escaping the fact that this was a serious oversight.

- At the conclusion of his report, Dr Craven provides an analysis of Leila's circumstances and in particular, whether Leila showed signs of a bowel perforation or peritonism at the time of her WCH presentation. He makes the obvious point that there were some concerning features that had been documented which do not need repeating. However, he suggests that on examination Leila was not found to have features of peritonism having regard to no apparent vomiting and with improvement in pain and tachycardia. I am not certain about the reference to improvement in tachycardia. I do take into consideration that Ms DeFrancesco thought that the monitor in cubicle 1 showed that Leila's heart rate had returned to normal levels, but as I have indicated, I do not accept Dr Pearton when she says that she measured Leila's heart rate during the review before discharge. There is no documentation of either except for Dr Pearton's retrospective note. Indeed, Dr Craven in his report states in connection with the ultimate assessment, '*this assessment would have been aided significantly by contemporaneous documentation in a normalisation of her clinical observations*'. There was no such contemporaneous documentation of normalisation. What documentation there is was retrospective in the case of Dr Pearton. With the exception of the recording of Leila's vital signs soon after her arrival at the WCH, Dr McMellon's notes contain no reference whatsoever to the taking of vital sign observations thereafter. I can only conclude that no further vital sign observations were taken.

- In the final observations as set out in his report Dr Craven refers to the question of hindsight. He concedes that in hindsight the circumstances in this case would

clearly have dictated that Leila should have been admitted for observation. If he himself had been the examining doctor he may have made the decision to admit for observation, but he asserts that it is also likely that based on the clinical improvement noted in the documentation that he would have discharged her home. In the light of the evidence of Dr Rieger, Dr Sebben and Associate Professor Raftos to the effect that Leila required a period of observation, I find this opinion extremely difficult to accept, and not just in hindsight.

19.3. As indicated earlier, Dr Craven gave oral evidence. It is not necessary to refer to all of his evidence because for the most part it repeats his very detailed first report. However, when Dr Craven was asked by Mr Bonig, counsel for Dr Pearton, to identify what apart from a raised temperature would be the other signs and symptoms of peritonitis if it has evolved at the 10 hour stage, Dr Craven in his answer ticked about every box that Leila displayed in terms of her symptomology at the outset. Yet, he suggested that it was highly unlikely that peritonitis was present because of Leila's response to the jump test[204].

19.4. In his oral evidence, Dr Craven was asked by Mr Bonig to clarify what he had meant in his report when he says that he could not see a '*clear indication*' that Leila should have been observed overnight. Dr Craven responded that a clear indication would be a symptom which one was concerned about, for example, if she continued to vomit. The point would need to be made that one might not necessarily be in a position to judge this without a period of further observation during which the child might well vomit. In the event, according to Mr Harkin Leila vomited into a bag on the way home in the car. Leila did vomit in the morning. Dr Craven did agree that if the child was admitted for observation and had continued vomiting, one would not discharge her, in the same way that if the pain had not resolved one would keep the child in for longer. Asked by me how you would know or be confident that a child would not resume vomiting, Dr Craven said that '*well you don't*'[205]. He then went on to explain that this is the reason why advice is given to parents to respond appropriately if vomiting resumes. In response to the suggestion that the vagueness and subjectivity of such advice might cause parents not to respond in the appropriate way, and for that reason it would be appropriate to keep the child in hospital under observation until one could be satisfied

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[204] Transcript page 713
[205] Transcript 718, line 7

that there was not going to be another episode of vomiting, Dr Craven referred to the pressure on the health system that such an approach would engender. The other relevant matter of course, as indicated in Dr Craven's report, was the location of Leila's family's place of living, an important consideration in determining whether one would keep a child for observation.

19.5. In cross-examination by Mr Harris QC, counsel for Dr Man, Dr Craven agreed that notwithstanding the pressure on the system one would not let a child go until one was satisfied on some basis or another that they did not have a solid organ injury[206]. However, Dr Craven went on to say that in medicine one could never be 100% sure of everything. Thereafter, Dr Craven and Mr Harris engaged in a debate about the degree of likelihood or unlikelihood of there being a serious injury that might dictate a period of observation. The debate culminated in Dr Craven rejecting the notation put by Mr Harris that if one was entertaining solid or hollow abdominal organ damage as a realistic possibility, one would keep the child in to observe. In doing so he suggested that Mr Harris was basing his argument on matters that we actually know happened, in other words that Mr Harris was positing that proposition purely on the basis of hindsight. I would reject that characterisation. It is difficult to understand why a child would be sent away at 1.00 or 1.30 in the morning back to her home in the country if there was a realistic possibility that the child had solid or hollow abdominal organ damage[207]. As well, on this issue Dr Craven asserted that as far as he is concerned the chance of having a significant abdominal injury in '*this sort of presentation*' are '*almost unheard of*'[208]. Asked by me as to how one could ignore the facets of Leila's original presentation so as to reach a point where the doctor could be satisfied that it was highly unlikely that the child had an internal injury, Dr Craven said that this was part of the clinical judgement the doctor had to make and stated that that is where the doctor has to actually examine the child him or herself to make a decision.

19.6. In cross-examination by counsel assisting, Ms Kereru, Dr Craven made a number of important concessions. He stated that he would have been concerned enough to definitely say that Leila should have been kept in overnight based on the high heart rate, the high respiratory rate, her temperature and the rigid abdomen which were found on

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[206] Transcript 721
[207] Transcript page 725, line 14
[208] Transcript page 728, line 9

her arrival if no further observations had been made in respect of Leila's condition[209]. In addition, he conceded that the distance from hospital to home would be another factor that would tip the balance in favour of admission[210]. Dr Craven added that the time of night would be another factor.

19.7. On the issue as to the question of a set of observations on discharge, Dr Craven suggested that it would have been a useful exercise to have taken the temperature during Dr Pearton's examination particularly if one had known that the child had been identified as febrile to begin with[211]. Dr Craven was asked the following:

> 'Q. If the child had been in the hospital for two hours, then you're saying that there should have been another set of observations done at some stage.
>
> A. Yes.
>
> Q. Between the first set and discharge.
>
> A. Absolutely, and with my hindsight of experience and wisdom, if I'm a little bit wary about a child going home, which might have been the case in this situation, I would often ask the nurses to do one more set of obs before they leave. And as I said to counsel earlier was that at that stage I've, on occasion, actually changed my mind as to my course of action because there was a change in the observations. So if I thought she looked very well but then she was still febrile and tachycardic I would probably say 'Look, let's just keep her overnight.'[212]

19.8. It will be remembered that Registered Nurse Basford said that she had intended to take a set of observations after Dr Pearton's review but that by the time that she came to do this, Leila had left. To my mind there was no second set of observations undertaken and so the decision to release had that fundamental flaw.

19.9. Dr Craven produced a second report which was in the nature of a rejoinder to Associate Professor Raftos' report. The salient features of the second report did not advance the debate significantly. Dr Craven suggests that contrary to Associate Professor Raftos' assertions, the jump test can be extrapolated as a valid part of the abdominal examination of looking for signs of peritonism. He agrees with Associate Professor Raftos' assertion that if the doctor suspected that Leila had an internal injury she should not have been discharged from hospital. Dr Craven also asserts that Associate Professor Raftos appeared to suggest that Leila should have been admitted for observation based on elevated heart rate alone. In his oral evidence Associate Professor

[209] Transcript page 738, line 30
[210] Transcript page 738, line 34
[211] Transcript page 743, line 16
[212] Transcript page 744, lines 8-23

Raftos eschewed that suggestion. Dr Craven also disagreed with Associate Professor Raftos' evidence that Leila's management should have been dictated on the basis of her triage alone, when regard is had to what appeared to have been a change in her condition post-triage. He also suggests that it was easy for Associate Professor Raftos in hindsight to second guess Dr McMellon and Dr Pearton's decision to discharge Leila home.

19.10. I indicate that I have preferred the evidence of Drs Rieger, Sebben and Raftos to the evidence of Dr Craven insofar as there are differences in their respective approaches to the question of whether Leila should have been kept at the WCH at least for observation.. To my mind it is clear that the opinions that Leila should have been kept for a period of observation are manifestly correct and not merely in hindsight.

20. Leila's chances of survival with timely surgical intervention

20.1. The evidence on this topic was given for the most part by Dr Rieger. This analysis is conducted on the basis of the acceptance of Dr Rieger's evidence, which I do accept, that Leila sustained her perforation at the time of her fall.

20.2. The analysis is also conducted on the assumption that surgical intervention was the only means that could have assisted Leila. I deal with this issue as it pertained at the various junctures during the course of Leila's illness since her fall, viz:

(a) After a period of observation in the early morning of 30 September 2015;
Dr Rieger suggested that if a bowel perforation had been identified at WCH after a period of observation, the outcome for Leila from surgical intervention would have been excellent. He believes that there would have been a small possibility of her dying from the injury as it cannot be said with absolute certainty that there would have been a good outcome. He indicated that there would have been potential complications relating to the injury and in respect of the surgery required to repair the injury, but that in a young otherwise fit 9 year old, one would have expected a good outcome. Having regard to the injury as he saw it in the post mortem photography, Dr Rieger suggested that Leila's would have been a straightforward surgical procedure. He explained that the perforation would be repaired, the abdomen would be washed out and then closed. Peri-operative antibiotics would have been given both at the time of surgery and post-operation. Leila would have been managed in the Paediatric Intensive Care Unit for perhaps

1 or 2 days. Dr Rieger suggested that he would have expected a very good outcome with Leila leaving hospital within 5 to 7 days. He outlined the risks related to the repair and the possibility of it breaking down and possible septic complications, but stated that this could have been managed by further drainage and that in all likelihood Leila would have done well. There is no evidence to the contrary. I have no hesitation in accepting Dr Rieger's evidence in this regard.

(b) After 7.30am on the morning of 30 September 2015 when Leila again started vomiting;

Once Leila had started vomiting again during the following morning, and if she had still been observed in the hospital at that time, Dr Rieger suggested again that the outcome would have likely have been favourable. He suggested that even up until midnight on 30 September / 1 October 2015 Leila was potentially salvageable, and even past midnight. As time progressed from that point, her chances lessened.

(c) During the afternoon or evening of 30 September 2015 following Leila's consultation with Dr Man;

Dr Rieger said that he believed that Leila's prognosis would have been good even at this stage. One would need to consider that there would have been delays in having to transport Leila back to the WCH. However, Dr Rieger did not believe that she had become overwhelmed by any sepsis that had occurred, and so he still believed that Leila's outcome would have been good if she had been operated on during the afternoon and evening of 30 September. However, he said that the chances of a favourable outcome would not have been as good as they would have been if intervention had occurred earlier. This is due to the fact that there would have been more sepsis involved and probably more derangement in respect of Leila's vital functions together with other complications. However, he said *'I mean still a 9 year old at this point in time I still think could do very well to be honest'*[213].

[213] Transcript page 491, lines 14-15

(d) If Leila had been brought into the Strathalbyn Hospital at approximately 5am on the morning of 1 October 2015;

Dr Rieger posed the pertinent question namely, when did Leila become unsalvageable? Dr Rieger was not able to answer that specifically. However, he mentioned that there were certain supports that she could have been provided with including intravenous fluid and antibiotics that might have improved the chances of a successful outcome. However, Dr Rieger told the Court that he believed Leila had reached the end point during the hours of the following morning and probably would have died in any event in that period. I asked Dr Rieger to consider what Leila's chances of survival would have been at approximately 5am on 1 October 2015 if she had been brought into the Strathalbyn Hospital at that time, bearing in mind that she would have needed to have been further transported to another hospital. To this Dr Rieger said that by then Leila had reached the end stage of her illness and that the expression *in extremis* was an appropriate description for her condition at that stage. Her prognosis was potentially very poor at that time. Dr Rieger believed that at the point where Mrs Harkin rang the hospital Leila was probably at or near death.

20.3. I accept all of Dr Rieger's evidence. Dr Rieger is an experienced colorectal surgeon. He had examined the photography of the child's injury taken at post mortem and has had regard to her presentation during the course of her illness.

20.4. I find that if Leila had been kept at WCH for observation, it is highly likely that she would have displayed further signs and symptoms of peritonitis. That being the case it is highly likely that a bowel perforation would ultimately have been diagnosed, probably by way of a CT scan. I find that it is highly likely that appropriate surgical intervention at that stage would have saved her life.

20.5. If Leila had been had been operated on during the following day, 30 September, either in the morning when she commenced vomiting or after seeing Dr Man, I find that it is likely that she would have survived.

20.6. I do not know for certain what Leila's chances of survival would have been if she had been brought into the Strathalbyn Hospital say an hour or two hours earlier than she was on the morning of 1 October 2015, but to my mind it is unlikely that the outcome would have been any different from what it ultimately was that morning.

21. Conclusions

21.1. The Court reached the following conclusions:

1) At approximately 1pm on Tuesday, 29 September 2015, Leila Baartse-Harkin jumped or fell from a swing at an out of school hours care facility at Eastern Fleurieu Primary School. I find that she fell from a height of at least 2 metres and possibly as high as 2.8 metres. I find that she fell in the act of pretending to fly. As a consequence she fell onto her front and in particular onto her abdomen, and she did so with a significant degree of force. It is probable that Leila fell with her left hand between the ground and her abdomen.

2) Leila suffered a fracture of her left wrist as a result of the fall.

3) I find that as a result of the fall, and at the time of the fall, Leila sustained a perforation of her small bowel. I find that from that point forward bowel contents leaked into her peritoneal cavity and that she developed peritonitis as a result.

4) After the fall Leila became unwell with vomiting and abdominal pain which were the result of the perforation to her small bowel. They were both signs of peritonitis.

5) On the evening of Tuesday 29 September 2015 Leila was taken to the Strathalbyn Hospital where she was seen by Dr Sue-Yin Man. Leila’s presentation at the hospital included vomiting within the hospital itself, abdominal pain and abdominal guarding. The history that Leila had fallen off the swing from an estimated height of between 8 and 10 feet caused Dr Man to become concerned that Leila may have suffered blunt internal trauma to her abdomen. As a result, Dr Man sent Leila to the WCH. Dr Man compiled a referral letter which was taken by Leila’s parents to the WCH. The letter was addressed to the Paediatric Emergency Department of WCH. It stated that Leila had jumped off a swing from a height of about 8 to10 feet and had landed on her hands and abdomen. The letter referred to Leila’s history of vomiting since that time and to the difficulty in examining her due to her vomiting being exacerbated by lying down.

6) Leila was triaged at approximately 11.40pm at WCH. I find that at triage Leila had a rigid abdomen due to involuntary guarding and that she exhibited abnormal breathing. Leila was also noted to be in significant pain in the abdominal region.

7) I find that shortly after triage, Leila's vital signs were measured by nursing staff. The figures were recorded on an observation chart. Leila had a raised temperature of 38C degrees, a raised pulse rate of 146 and a raised respiratory rate of 36 with a pain score of 7 out of 10 which is severe. Leila's breathing was noted to be fast and unusual. Her oxygen saturations were measured at 100% which is normal. I find that Leila's abnormal signs and her symptomatology including the rigid abdomen and abdominal pain were symptomatic of peritonitis due to a bowel perforation.

8) At triage Leila was experiencing a level of pain that caused nursing staff to conclude that she would need a wheelchair to be conveyed to the Emergency Department treatment cubicles.

9) In cubicle 1 Leila was examined by Dr Amy McMellon, a Paediatric Registrar. Dr McMellon noted the results of Leila's vital sign observations, assigning in her clinical note correct figures for the pulse rate of 146 and for the respiratory rate of 36. Dr McMellon noted in the progress notes that Leila was afebrile. This was incorrect. Leila was febrile. She had a temperature that was elevated above the norm. I find that Dr McMellon considered that Leila was afebrile because she misread the temperature of 38 as 36. Whereas 38C degrees is an elevated and febrile temperature, 36C is a normal temperature. This was an error on Dr McMellon's part that in no sense can be viewed as reasonable. At worst, the temperature figure of 38 written by nursing staff was ambiguous and should have been viewed as such by Dr McMellon. That the temperature in reality was 38 could easily have been established either by Dr McMellon examining the figures against other figures on the chart or by asking nursing staff who were still present in cubicle 1. I find that this error, perpetuated as it would be by another medical practitioner, Dr Elissa Pearton, rendered Leila's further management at the WCH as fundamentally flawed. No account was ever taken of Leila's raised temperature and no consideration was given to it as to whether or not it may have been a sign of an internal traumatic injury.

10) I find that the South Australian Trauma System - Trauma Team Activation Criteria Level 1 Trauma Team Activation had been enlivened for the following reasons:

    a) Two of the normal vital sign limits had been exceeded insofar as Leila had an abnormal heart rate and an abnormal respiratory function in that her respiratory rate was abnormally high and she exhibited some respiratory abnormalities. On reading the criteria I do not believe that abnormally low blood pressure is required to activate Level 1 and I do not believe that a low oxygen saturation level is necessarily required. Any one or more of the abnormalities referred to in the physiological profile should trigger the Level 1 response if its terms are correctly read;

    b) Leila's injury profile also fulfilled the necessary criteria in that she was experiencing severe pain and involuntary guarding in respect of her abdomen. If I am wrong about the Level 1 Trauma Team Activation being enlivened on the strict reading of the criteria, Leila was so close to fulfilling those criteria that serious consideration should have been given to whether in any event, based on the facets of her presentation, she should have been subjected to a surgical review at a minimum and at the first available opportunity. As well, the Management Guidelines for Abdominal Injury contained within the WCH Trauma Manual stated that the paediatric surgery team must be consulted in all cases of suspected abdominal trauma. I find that abdominal trauma was reasonably suspected. A perusal of Dr Man's referral letter in my view was sufficient to raise a reasonable suspicion that Leila had experienced abdominal trauma. Although the letter did not raise that as a possibility in terms, the described circumstances of Leila's fall, the impact with her abdomen and her presentation since could only have been interpreted as raising a reasonable suspicion on the part of Dr Man that Leila had suffered an abdominal trauma. That suspicion was, if anything, enhanced when Leila was triaged and her vital signs were measured. Accordingly, I find that even by reference to the Management Guidelines, a paediatric surgery team should have been consulted at the first available opportunity. If in the circumstances the only member of a paediatric surgery team was a surgical registrar, then

that person should have been obtained to examine Leila at the first available opportunity.

11) X-rays taken of Leila's chest and abdomen were correctly assessed as demonstrating no abnormality. However, the x-rays should have been regarded as inconclusive insofar as it is universally understood that free gas within the abdomen, a sign of bowel perforation, might only be detected by x-ray in a limited number of instances and that there is a high proportion of false negatives associated with this modality of diagnosis.

12) It is apparent to me and I find that no, or no adequate, consideration was given to the administration of a Focused Assessment with Sonography in Trauma (FAST) scan which is an ultrasound diagnostic modality. I am not certain whether the administration of such a scan was considered in Leila's case having regard to divergent views in the medical profession as to its utility. There is no means by which it can now be established whether Leila had emitted from her bowel perforation a sufficient volume of liquid that may have been detected by way of a FAST scan if administered at the outset at the WCH. However, I find that there was no reason or circumstance standing in the way of a FAST scan being administered serially over a period of time if Leila had continued to remain under observation for the rest of the night. The difficulty was that Leila was discharged from the hospital.

13) Leila was provided with paracetamol analgesia at 11:57pm and ibuprofen analgesia at 12:45am. Leila was x-rayed between midnight and 12:30am. I find that in the period following her x-rays Leila displayed some improvement. It has been difficult for the Court to judge the level of improvement or how that may have manifested itself to clinical staff at the WCH. Leila's parents, Mr and Mrs Harkin, both accept that there was a level of improvement. I do not know precisely what the explanation for Leila's level of improvement was except that it is consistent with the analgesia that she had been administered. Other explanations might include humouring by Mr Harkin and possibly others, a possible sense of reassurance on the part of Leila herself when it was revealed that her x-rays displayed no abnormality, a possible sense of reassurance in Leila by reason of a reduction in the level of pain that she had been experiencing, the fact that Leila had been provided with a backslab for her broken wrist and even

possibly a general attitude of stoicism on the part of Leila coupled with a desire to go home.

14) Leila was reviewed by Dr Elissa Pearton prior to her discharge from the WCH. The review took place in the presence of Leila's parents, Mr and Mrs Harkin, and Dr Amy McMellon. I do not believe that Leila told Dr Pearton, by one-word negative answers, that she had not fallen on her chest and had not fallen on her stomach. In any case I do not accept that either Dr McMellon or Dr Pearton gained any reasonably held sense of reassurance that Leila had not suffered a significant impact to her abdomen from anything Leila said during the course of this review. Dr McMellon and Dr Pearton should have proceeded in this review on the already clearly established understanding that Leila had fallen from a height of, or greater than, 2 metres and that she had experienced a significant impact to her abdomen. Indeed, I find that the only information that had been gathered about the circumstances of Leila's fall was information that from the very beginning until the very end had reasonably given rise to a concern that Leila had experienced a significant internal injury.

15) The review of Leila by Dr Pearton was instigated by Dr McMellon who genuinely and reasonably believed that Leila should not be permitted to leave the hospital until her pain had resolved. I find that during the review Leila was still experiencing pain, although not at the level of pain which she had been experiencing at the time she had arrived at the hospital. I am uncertain as to the manner in which Leila exhibited pain during the course of this review. I have found it impossible to accept that Leila would have been as completely free of pain as described by Dr Pearton and Dr McMellon. It is possible that Mr and Mrs Harkin were more attuned to Leila's continued discomfort than were the medical practitioners in the light of Leila's parents' obvious greater familiarity with her.

16) I find that Dr Pearton did not assess Leila's vital signs by the use of a stethoscope or by any other means. Leila's vital signs had not been observed since 11:50pm when they had been taken by registered nurse Ms Defrancesco. They should have been taken and recorded hourly. They should have been taken and recorded at a time of 12:50pm and again taken on her discharge from hospital. They were not so taken. I find that registered nurse Chloe Basford had wanted to take Leila's

observations prior to her discharge but did not have an opportunity to do so because Leila had already been discharged. The failure to take vital sign observations other than in the first instance was a serious departure from normal procedures. The only observation that was made following the formal set of observations that were taken by Ms Defrancesco at 11.50pm was a vague and casual sighting of what Ms Defrancesco had believed to have been a return to a level of normality in relation to Leila's heart rate as exhibited on the heart rate monitor. That to my mind was not a satisfactory manner in which a child's vital signs should be assessed especially when in the first instance the vital signs had been identified as abnormal.

17) The only temperature taken in respect of Leila was the febrile temperature of 38ºC taken and recorded by Ms Defrancesco at 11:50pm. It is clear that Leila's temperature should have been re-taken subsequently to that time and taken again prior to discharge, and taken by Dr Pearton in particular during the course of her review. I find that both Drs McMellon and Pearton unreasonably had concluded that Leila's temperature was an afebrile 36ºC when the correct figure could easily have been established with appropriate diligence. The failure to determine whether or not Leila's temperature had descended to normal levels was a significant missed opportunity to have properly considered her clinical status. The failure to take and record further observations of other vital signs could also be so characterised. In any event, as already seen, on the basis of the abnormal observations taken in the first instance and the clinical observations relating to Leila's abdomen and her pain, a surgical review should have been obtained as soon as possible and at a time prior to the flawed review conducted by Dr Pearton.

18) I find that Dr Pearton's review miscarried insofar as it (a) was based on an unwarranted sense of reassurance that Leila's fall had not been as serious as first thought, (b) because it did not take into consideration that Leila had presented with a raised temperature, (c) it did not give sufficient weight to Leila's original clinical presentation of pain and abdominal guarding and (d) did not involve the taking of vital signs. The decision to discharge Leila was flawed for the same reasons. The decision is mitigated by the fact that Leila had improved and did not display as much pain as before, but insufficient regard was had to the analgesia that had been administered.

19) Leila should have been kept in the WCH for observation. She should not have been discharged. I am not certain that a CT scan should immediately have been administered upon Leila's presentation to the WCH, but a period of observation overnight would have revealed Leila's continuing state of unwellness and have ultimately led to the administration of a CT scan of her abdomen. I have no doubt that a CT of her abdomen would have revealed her internal pathology. A period of observation would also have enabled serial applications of FAST scans. It is not possible to determine with certainty whether a FAST scan would have revealed fluid within the abdomen, but it was a measure that was available and could easily have been utilised. In any event, it is the finding of the Court that Leila's continuing unwellness would have been revealed after a period of observation and that this would have resulted in Leila being diagnosed with a serious internal injury. It would have further led to appropriate surgery for the repair of that injury.

20) I am unable to make any finding in relation to the nature and quality of any advice that was given to Mr and Mrs Harkin on Leila's discharge.

21) Leila was discharged from the WCH. I find that she vomited in the car on the way home and awoke early the following morning with continued abdominal pain and renewed vomiting. There is no reason to suppose that all this would not have manifested itself in the WCH if she had been kept there for observation.

22) Leila continued to manifest illness during the course of Wednesday 30 September 2015. As a result Mrs Harkin took her to see Dr Man during the afternoon of that day.

23) Dr Man did not physically examine Leila nor take any vital sign observations. I find that this was a serious miscalculation on her part. Dr Man derived reassurance about Leila from the fact that Leila had been discharged from the WCH to which Dr Man had sent her in the first instance. Dr Man also believed that Leila had undergone an ultrasound as well as x-rays. Dr Man was not provided with any discharge letter from the WCH. I find that Dr Man's assumption that Leila had been fully cleared of serious pathology at the WCH was understandable but unfortunately unwarranted. It was not reasonable for Dr Man to have assumed that Leila had undergone an ultrasound. However, a properly

constructed discharge letter from the WCH would have alerted Dr Man to the fact that no ultrasound test had been performed. I accept her evidence that if she had detected this fact from a discharge letter she would probably have queried this with the hospital and would have possibly considered sending Leila in again for a further review. Dr Man accepts that she should have at least subjected Leila to a physical examination. I find that this probably would have revealed enough for Dr Man that afternoon to have sent Leila either for CT scanning at Mount Barker or back to the WCH.

24) Leila continued to remain ill throughout the course of the rest of 30 September 2015 and into the following morning by which time she was in extremis. Leila was taken to the Strathalbyn Hospital where after a prolonged period of attempted resuscitation she was declared deceased.

25) I find that there is a very high degree of probability that Leila's death was preventable. It was preventable at different junctures throughout the course of her illness. I find that her death would probably have been prevented by abdominal surgery if Leila had been kept in the WCH and had been observed overnight. I find that if Leila had been properly examined by Dr Man on the afternoon of 30 September 2015 it is likely that she would ultimately have been returned to the WCH and that she would have been correctly diagnosed in time for effective surgical intervention to have taken place that afternoon or evening, thereby probably preventing her death. I find that by 5am on the morning of 1 October 2015 Leila had deteriorated to such an extent that surgery would have been highly unlikely to have changed the outcome.

22. Recommendations

22.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest. In my view this power is not restricted to the making of recommendations that would identifiably have prevented the particular death under investigation, in this case the death of Leila Baartse-Harkin. The power is broader than that. It looks to the future. It enables the Court to identify measures that might prevent deaths similar to that which is the subject of the coronial inquiry. Accordingly, some of the recommendations below

might be said not to be evidence based with respect to the particular findings of fact attached to Leila's death. However, they are crafted in the hope that they will ensure that something as tragic and as unnecessary as Leila's death never happens again. Many of the measures that I will describe have in fact been based on suggestions that have emanated from Mr and Mrs Harkin and her legal representatives.

22.2. I will deal with two broad issues that might conceivably be the subject of the Court's recommendations, namely measures that might be initiated at out of school hours care facilities that would either prevent injury or stimulate the seeking of medical treatment when a traumatic injury is identified or suspected, and secondly, recommendations in relation to practices within hospitals including country hospitals such as the Strathalbyn Hospital, and the Women's and Children's Hospital, particularly in respect of paediatric trauma.

22.3. Ms O'Connor SC on behalf of Mr and Mrs Harkin has invited the Court to consider making certain recommendations in relation to out of hours school care programs. These recommendations for the most part concern the need to seek medical advice in respect of children under the care of such a facility when a traumatic injury has occurred or is suspected. One recommendation that the Court has been invited to consider is that all staff in these facilities should be trained in first aid and be trained in the application of guidelines such as the Trauma Activation Guidelines that exist in South Australia to which reference has been made in the body of these findings. I am unaware of whether there is any requirement for out of school hours care facility staff to have any kind of first aid training or whether it is feasible for such training to be insisted upon. In addition, I am not entirely certain that staff trained in first aid would necessarily be able to apply guidelines such as the Trauma Activation Guidelines unless some further and more advanced medical training was provided. The other difficulty of course is that these guidelines depend upon clinical evaluation, and in particular the taking of vital sign observations and the evaluation of them. It is also suggested that a worthwhile measure would be insistence that when children present with pain following an injury, that their temperature and pulse at least should be ascertained and where necessary an ambulance or doctor should be called at a time prior to the collection of the child by a parent. Again, I am not certain that carers at these facilities would have the necessary skills to consistently apply measures such as these. All this Court can say is that suggestions such as these are worthy of further consideration by the relevant authority.

22.4. That said, I would agree that in cases where a child at a facility such as this has experienced a serious traumatic impact, immediate consideration should be given to whether or not medical assistance should be immediately sought. For example, I would have thought it axiomatic that from now on if a child falls from a significant height, and that would be a height of two metres or more, it might be considered appropriate to seek immediate medical assistance, particularly in circumstances where a parent or other carer is not immediately able to attend and collect the child. This indeed might frequently be the case because in many instances the child is in an out of school hours care facility because their parent is elsewhere, at work or in other circumstances that would prevent their immediate attendance. For the sake of consistency, there would need to be very strict guidelines with no grey areas and with no discretions for an initiative of this kind to be workable. Ideally, a parent or other relative or carer should immediately be contacted whenever a serious traumatic incident has occurred in respect of a child. There should be no delay in calling that person. There should be insistence in those circumstances that a parent or other responsible person in respect of the child attend without undue delay. I am not certain that these kinds of measures are going to be feasibly implemented at all times. However, the Court is prepared to make a recommendation in respect of this issue and it will be set out below.

22.5. Mr Keane, counsel for the Minister for Health, the Women's and Children's Health Network and Country Health SA, produced to the Court documentation that relates to measures that have been recommended and/or implemented within SA Health and Country Health SA and which have been identified as a result of Leila's death. Tendered to the Court was a document entitled **'Evaluation of the impact of quality improvement strategies undertaken to mitigate the risks identified from a review of the care provided to Leila Baartse'**[214]. The document sets out eight improvement strategies. Included among the strategies are measures that are designed to ensure that Trauma Activation responses are properly considered and not overlooked. Another is that clinical information on presentations, diagnosis, management and referral of abdominal injuries are included within the Trauma Manual. There are other strategies relating to the process of discharge including the nature of information that should be provided to patients and their carers. In respect of this issue a new form has been developed[215]. A copy of the form as completed by WCH staff would be provided to the

[214] Exhibit C22f
[215] Exhibit C31

patient or the patient's carer and the original would be filed in the patient's medical record. Having perused this document carefully it is apparent that there is a requirement within the form that a discharge diagnosis is to be identified, that investigations performed be described and that the specific discharge advice provided to the parent or carer is inserted onto the document. There is also provision for a description of follow-up that would be provided to the parent including whether a follow-up phone call would need to be made to the child's parents after discharge, a measure that I will say something more about in a moment. The provision of this document would address some of the issues that have been identified in this Inquest including the provision and recording of clear and certain discharge advice to the parent as well as a discharge diagnosis, that in reality in Leila's case was never arrived at. The part of the document that requires the investigations performed to be identified would also enable medical practitioners who might see the same patient following discharge, such as Dr Man in Leila's case, to see specifically what investigations have been performed including x-rays, CT or MRI scans and ultrasounds. During submissions about this document, I pointed out to Mr Keane that there is nothing within the document about vital sign observations. It seemed to me that if there was a requirement that observations taken at or near discharge be included in the document, this would ensure firstly that the observations were actually taken and, secondly it would ensure that the fact of the observations and their numbers were properly recorded, not only for the benefit of the discharging hospital and staff, but also for the benefit of any other medical practitioner who might see this document following discharge, such as Dr Man in this case. I intend to make a recommendation accordingly.

22.6. There are other improvement strategies identified including a requirement that all Priority 1 and 2 patients who are discharged home from the Paediatric Emergency Department of the WCH should receive a general practitioner discharge letter prior to leaving the Department. I understand that this letter would be provided even where the patient had to wait for its compilation and provision. It will be remembered that the discharge letter in respect of Leila was compiled belatedly and was not seen by Dr Man on the afternoon of 30 September 2015. It will also be remembered that Dr Man would have been troubled by the contents of that letter and that it would have prompted her to make inquiries about the nature of tests that had been undertaken at the hospital.

22.7. There is also an improvement strategy that would require all trauma patients who have presented after hours and who are discharged home to receive a follow-up call from the Trauma Clinical Practice Consultant. The impact that this measure is said to generate is that it would ensure that the '*carer*', that is to say the parent in most cases, has understood the care and treatment required for the child and it also would provide an opportunity for carers to ask questions. It occurs to the Court that the phone call would also provide the parent with an opportunity to advise the Trauma Clinical Practice Consultant as to whether any signs or symptoms within the child had re-emerged since discharge. This would have been useful in Leila's case. Leila in the morning resumed vomiting, was experiencing ongoing pain and according to Mrs Harkin also had a worrying temperature. I have little doubt that if a follow-up phone call had been made to Mrs Harkin during 30 September 2015 it would have resulted in Leila being returned to the WCH and being properly diagnosed and treated. The Court cannot overstate the importance of a requirement such as this. To my mind such a phone call would very likely have prevented Leila's death. The only other comment I would make is that I am not sure why this requirement would be confined to trauma patients who have presented after hours. It seems to me that there would be a number of instances where children discharged during normal working hours are as much at risk as those discharged after hours. I therefore intend recommending that this measure be extended to all paediatric trauma patients who have been discharged.

22.8. Other improvement strategies include requirements that Priority 1 and 2 patients' care should, in certain circumstances including where their physiological observations fall outside certain parameters, be discussed with an Emergency Department consultant prior to discharge home. There is also a requirement that observations must be repeated prior to discharge home, a measure that would seem to be fundamental and one that would not necessarily need to be spelt out in a document such as this. Nevertheless, the fact that the requirement that observations should be repeated prior to discharge is now clearly spelt out is a refreshing development.

22.9. There are other measures relating to the escalation of care within the Emergency Department of the WCH including the introduction of an RDR[216] observation chart which is designed to serially record all physiological observations. It also provides for certain medical responses in certain circumstances, responses that might be triggered

[216] Rapid Detection and Response

by observations exceeding identified figures in the case of respiratory rate, pulse rate and temperature. I observe that by virtue of this document that on Ms Sanders' analysis, in which she identified a pulse rate that she believed was in excess of 150, Leila would have received a Medical Emergency Response. As it was, Leila's measured pulse rate of 146 would have gone very close to dictating that kind of response.

22.10. Finally, the quality improvement strategy document contains a strategy described as follows:

> 'Introduction of the Escalation of Care System, including Family, MET Call throughout WCHN.'

This measure is designed to empower a family to escalate their concerns on the clinical state of their child. I understand that this measure is one that would be enlivened in respect of a patient within the hospital. It occurs to the Court that there would also be a need for a similar strategy to be implemented in respect of patients who have been discharged but where the family either continues to remain concerned about their child or where the concerns re-emerge for whatever reason.

22.11. Also provided to the Court was a further document that is related to the previously identified improvement strategy document that contains further more specific recommendations for change. I understand that these recommendations have been crafted by Ms O'Connor SC on behalf of the Harking family. This document is attached to this finding as Appendix 1. I intend making a broad recommendation that the measures and initiatives set out in that document be implemented in full.

22.12. It will be observed from Appendix 1 that there is reference to an escalation of care system also being made available to those located in Emergency Department waiting rooms as the current 'Family MET Call' process appears to be only available to patients that have been admitted. I have already made reference to what appears from the originating improvement strategy document to be a deficiency. Also in this document is a reference to the Leila's Lifeline Campaign and to a motion passed in Parliament regarding that. In her written submission to the Court, Ms O'Connor SC on behalf of Mr and Mrs Harkin has also invited the Court to consider the establishment of a dedicated service and that it be named Leila's Lifeline. I agree that it would be appropriate that Leila's identity and persona adhere to this measure for the reasons identified in Appendix 1 of these findings.

22.13. The written submissions of Ms O'Connor SC contain a number of other recommendations that she invites the Court to consider. I have considered all of those suggested recommendations and I have adopted most of them as set out below.

22.14. The Court makes the following recommendations directed where appropriate to the Minister for Health, the Chief Executive of SA Health, the Chief Executive Officer of Country Health SA, the Minister for Education and Child Development, the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine and the South Australian Board of the Medical Board of Australia and the Young Men's Christian Association:

1) I recommend that the WCHN 'Paediatric Emergency Department Patient Discharge Information' document contain detailed information relating to vital sign observations taken immediately prior to discharge.

2) I recommend that Improvement Strategy 5 as set out in the document entitled 'Evaluation of the impact of quality improvement strategies undertaken to mitigate the risks identified from the review of the care provided to Leila Baartse' be extended in its operation to include a requirement that all trauma patients, regardless of the time of presentation, receive a follow up phone call from the Trauma CPC.

3) I further recommend that the improvement strategies identified in the document entitled 'Evaluation of the impact of quality improvement strategies undertaken to mitigate the risks identified from a review of the care provided to Leila Baartse'[217], insofar as any of those strategies are yet to be implemented or have only been implemented in part, be fully implemented as soon as possible.

4) I further recommend that the additional recommendations and general recommendations contained within Appendix 1 herein, insofar as any of those measures have not been implemented or have only been implemented in part, be fully implemented as soon as possible.

[217] Exhibit C22f

5) I further recommend that the following measures, as identified in Ms O'Connor SC's written submission, be implemented as soon as possible:

a) *Recommendation 6* - That there be a review of the country hospital emergency teams and services available and back up and staffing levels assessed for after-hours services.

b) *Recommendation 7* - That a doctor be available on site for all hospitals purporting to be an emergency hospital at all times.

c) *Recommendation 9* - That the Strathalbyn Hospital adopt a policy of ensuring that they obtain a copy of a discharge summary for all patients referred to another treating hospital because it is likely, should a patient return for further treatment and assessment, that they would come to their local hospital.

d) *Recommendation 11* - That all discharge summaries are either given to a patient on discharge or emailed to them as soon as possible after the discharge. Patients, especially with young, ill children may not want to wait for a doctor to have free time to prepare such a document but, it is submitted, in this day and age the use of emails is a common communication tool.

e) *Recommendation 12* - Discharge summaries should not be posted to a general practitioner at all. Most doctors are on the health system computer and faxes and emails are a common form of communication between services.

f) *Recommendation 13* - A patient, if an adult, or a carer, if a child should be provided with instructions in writing about the service and treatment received, the likely diagnosis and prognosis and what signs should result in the patient being presented again at an emergency department.

g) *Recommendation 14* - Patients or their carers should be told the reason for particular tests or concerns.

h) *Recommendation 15* - No patient should be released from a hospital where protocols require that observations be conducted without a set of observations taken, and recorded before release.

i) *Recommendation 16* - No assessing or reviewing doctor should do so without seeing all the information about a patient including the observations, triage observations, and any referral letter.

j) *Recommendation 17* - A child should not be discharged with undiagnosed abdominal injuries where one of the following is still present:

i. Pain in the abdomen even if dissipated over time especially if analgesics given
ii. Elevated heart rate of more than 5% above normal range for age group
iii. Lack of consumption of food and water recorded in the case notes
iv. Continued nausea of vomiting
v. Where the parents or carers live more than 30 mins from the accident and emergency service treating the child
vi. Where the parents or carers live more than 30 mins from an emergency 24 hour hospital
vii. Where there is a report of a fall in excess of 2 metres.

I have not included reference to the observation within this recommendation that x-rays are an outdated diagnostic tool for abdominal soft tissue injuries as I was not persuaded that this is necessarily the situation in all cases. Clearly it is of value if it reveals an abdominal soft tissue injury which it well might do in some cases. However, I agree that limited reliance can be placed on negative abdominal x-rays as a diagnosis of abdominal soft tissue injury.

k) *Recommendation 19* - That there be created a dedicated service (spoken about by the Harkins as Leila's Lifeline which has received appropriate support) which would enable a patient or carer discharged from a hospital and who is concerned about the treatment, diagnosis or prognosis of the patient, to access a medical service that would have full and immediate access to the hospital from which the patient has been discharged and to the clinicians responsible for the patient's discharge. There should be a requirement that in any such referral, the hospital from which the patient has been discharged and the clinicians responsible for the patient's discharge cooperate fully and in a timely manner with such a service.

I have reworded this recommendation. I indicate that the Court specifically endorses this suggested recommendation and further recommends that the initiative and dedicated service be publicly described as **<u>LEILA'S LIFELINE</u>**.

l) *Recommendation 21* - That each practitioner who sees part of the file should initial it so that it is clear that all those assessing and treating have appropriate knowledge of the information given.

I indicate that I have not set out Ms O'Connor's recommendations numbered 10 and 18. I intend to reword those recommendations below. I do not understand recommendation 20. I am not certain that recommendation 22 concerning the activities of radiographers is necessary or capable of feasible implementation.

22.15. I add the Court's following <u>recommendations</u>:

6) That educators, carers and staff at out of school hours care facilities throughout South Australia be advised that they should be vigilant in respect of the activities of children under their care, and in particular be encouraged oversee the activities of such children in respect of play equipment such as swings.

7) That educators, carers and staff at out of school hours care facilities throughout South Australia be advised that falls from heights of two metres or above should require immediate consideration to be given to whether medical assistance should be provided to the injured child. They should also be advised to contact a parent or other responsible person immediately and to insist on the attendance of that person for the purposes of the collection of the child.

8) General practitioners and other medical practitioners, who either within their practices or within the Emergency Department of a country hospital who are asked to examine a child who has been the subject of trauma and who has been discharged from the Emergency Department of a tertiary hospital, should immediately contact the tertiary hospital to ascertain the nature of the discharge diagnosis, the nature of investigations that were performed in respect of the child, the condition of the child on discharge including the details of the final set of observations, and to advise the tertiary hospital as to the current presentation of the child and seek advice as to the appropriate course of action. The general practitioner or other practititioner should not merely rely on the advice of the patient or the patient's carer or on the patient discharge summary, especially when in doubt as to the appropriate course of action.

9) I further <u>recommend</u> that in order to prevent any misunderstanding on the part of a medical practitioner in an Emergency Department of a hospital as to the nature of any vital sign observation, that the medical practitioner should confirm verbally

with the member of the nursing staff or other person who has taken those observations that the observation figures are in fact as they appear to have been written.

10) That the South Australian Trauma Team Activation Criteria in relation to a Level 1 Trauma Team Activation be clarified and amended to conform with the Sydney Children's Hospital Emergency Department Trauma Call Criteria Guideline. Alternately, I recommend that the South Australian document in respect of the Level 1 Trauma Team Activation be clarified and amended so that an abnormal respiratory function would include specifically an abnormal respiratory rate. I further recommend that the expression 'laboured respirations' be clarified. I would further recommend that under the heading 'Injury Profile', voluntary guarding as well as involuntary guarding be included within the abdominal symptomatology described.

11) I further recommend that appropriate education be delivered to all clinicians including Emergency Department medical practitioners and nursing staff in the WCH concerning the circumstances in which both Level 1 and Level 2 Trauma Team Activation responses should be initiated.

12) I further recommend that in all cases of presentations of suspected abdominal trauma within the WCH Emergency Department clinical staff perform their clinical duties on the basis of the possible worst case scenario and that when in doubt the patient should be kept for a suitable period of observation before discharge, regardless of whether or not from a clinical point of view the child has improved. The view should be taken that the child should not be discharged if the diagnosis is not completely clear, or where the possibility that the child has suffered a serious internal abdominal injury has not been completely excluded to the satisfaction of a medical practitioner at Consultant level.

13) I further recommend that in all cases where there is an element of doubt about the child's diagnosis, and that there is a suspected internal abdominal injury, a surgical opinion should be obtained at the outset.

Key Words: Peritonitis; Paediatric Diagnosis

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 22nd day of June, 2017

____

Deputy State Coroner

Inquest Number 40/2015 (1783/2015)

Appendix A

Recommendations related to the 'Evaluation of the impact of quality improvement strategies undertaken to mitigate the risks identified from a review of the care provided to Leila Baartse

RECOMMENDATIONS RELATED TO THE 'EVALUATION OF THE IMPACT OF QUALITY IMPROVEMENT STRATEGIES UNDERTAKEN TO MITIGATE THE RISKS IDENTIFIED FROM A REVIEW OF THE CARE PROVIDED TO LEILA BAARSTE (sic)'

Discharge Care:

Point 3: *'PED discharge information form developed and implemented in the WCHN PED which documents specific discharge information is given to carers and filed in the case notes.'*

Additional recommendations:

1. Implementation of the use of this from within ***all*** SA Health/Country Health Emergency Departments.
2. Discharge summary is given to carers/consumers before discharge, even if this means they must wait for it to be prepared.
3. Each discharge summary contains appropriate and clear information so that consumer/carer has a full understanding of what is required for the ongoing care, management, and monitoring of the patient, inclusive of risk, actual or possible diagnosis symptoms to watch for and which is the most appropriate service to access follow-up treatment should the consumer's symptoms and condition worsen.

Point 4: *'All Priority 1 and 2 patients who are discharged home from PED receive a GP Discharge letter prior to leaving the department.'*

Additional recommendations:

1. All ED patients, not just Priority 1 and 2 patients/carers, receive a discharge letter for their GP or any other referral source (hospital, specialist etc.) ***and*** a discharge summary for the consumers' use (as in Point 3).
2. Discharge letter includes vital observations e.g. blood pressure, heart rate, temperature.
3. Most recent audit showed 75% compliance. Processes need to be put in place to ensure 100% compliance.

Point 5: *'All Trauma patients that present after hours and are discharged home receive a follow up call from the Trauma CPC.'*

Additional recommendations:

1. All SA Health/Country Health EDs provides discharged patients and/or their carer a dedicated phone number to the Trauma CPC so that questions or concerns they may have that may not necessitate a 000 call or because they are not eligible to escalate care using the Family MET Call are addressed promptly. This may require the development of a specific clinical role to meet this need.

Point 6: *'All presenting Priority 1 and 2 patients are to be discussed with an ED consultant on clinical duty prior to discharge home if physiological observations outside of the RDR parameters. These observations must be repeated prior to discharge home.'*

Additional recommendations:

1. Observations are cross checked by 2 clinicians (nurses or doctors) to ensure legibility ***or*** a specific form is introduced which requires the clinicians to enter the observations within a grid of specified parameters e.g. temperature ranges: normal, low grade, medium grade, high grade

* In this document the word 'carer' refers to a patient's parents, siblings, family members, guardians, partners, friends or 'person responsible' who accompany a patient to a hospital as a support

** In this document a consumer is anyone who engages or may potentially engage with SA Health as a patient or carer*

Escalation of care:

Point 8: *'Introduction of the Escalation of Care System, including the Family Met Call.'*

Additional observations and recommendations:

1. There is limited information on language interpretations on the back of the 'Family MET Call' brochure and none on the poster, making it virtually inaccessible for culturally and linguistically diverse groups. At the very least the brochure should be translated into commonly used languages e.g. Vietnamese, Farsi, Cantonese, Sudanese Arabic, Hindi etc.
2. People who may need to use an escalation process may not be 'Family'. Calling this process, the 'Family MET Call' makes it less accessible to carers who are not related to the patient by blood or marriage.
3. The escalation process should also be available to those located in emergency department waiting rooms. Currently 'Family MET Call' process appears to only be available to patients who have been admitted.
4. The escalation process title 'Family MET Call' is obscure and generic. Obviously, Leila's family would like their campaign for Leila's Lifeline and the motion passed by Parliament to be honoured. By linking an escalation process to an actual story of a preventable death clinical staff are reminded of the importance of listening to consumer's instincts, concerns, and observations. Queensland Health have wisely chosen to call their escalation process Ryan's Rule in acknowledgement of a preventable death of a child within their hospital system and it is recommended that SA Health follow their lead.
5. The escalation process needs to be promoted properly and incorporated into the information that consumers receive in writing upon presentation to an ED.
6. This escalation process should be introduced to all SA Health/Country Health EDs.

GENERAL RECOMMENDATIONS

1. An audit of SA Health's and Country Health's compliance with the current carer/consumer related Acts, Charters and Policies that they publicly state they endorse and utilise, along with their accompanying processes and guidelines, with a particular focus on Emergency Departments and with the aim of implementing best practice and which seeks to embrace carer/inclusive practices. In particular, whether SA Health and Country Health are complying with:
    - the South Australia Carers Recognition Act 2005: https://www.legislation.sa.gov.au/LZ/C/A/CARERS%20RECOGNITION%20ACT%202005.aspx
    - the Policy Directive: Partnering with Carers: http://www.sahealth.sa.gov.au/wps/wcm/connect/064a90804a2136c38110e190d529bdaa/Directive_Partnering+with+Carers+Policy+Directive_110915.pdf?MOD=AJPERES&CACHEID=064a90804a2136c38110e190d529bdaa
    - the Policy Directive: A Framework for Active Partnership with Consumers: http://www.sahealth.sa.gov.au/wps/wcm/connect/59bbc2804e45470da9e9af8ba24f3db9/Directive_Framework+for+Active+Partnership+with+Consumers+and+Community_June2016.pdf?MOD=AJPERES&CACHEID=59bbc2804e45470da9e9af8ba24f3db9

- Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care: https://www.safetyandquality.gov.au/wpcontent/uploads/2012/10/Standard9_Oct_2012_WEB.pdf
- Your Rights and Responsibilities: A Charter for Consumers of the South Australian Public Health System: https://www.sahealth.sa.gov.au/wps/wcm/connect/8be0bd004324a784bb78fb15eab6e6ef/16002.1+Rights+%26+Responsibilities+A5+Booklet-v11.pdf?MOD=AJPERES&CACHEID=8be0bd004324a784bb78fb15eab6e6ef
- Country Health SA Local Health Network Strategic Plan 2015-2020 'Our Values': https://www.sahealth.sa.gov.au/wps/wcm/connect/bce5060049abf7459368df9b6ca12d15/14049.3+CHSALN+Strategic+Plan+2014-ONLINE.pdf?MOD=AJPERES&CACHEID=bce5060049abf7459368df9b6ca12d15
- Any other relevant National Safety and Quality Health Service Standards: https://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf

2. The introduction of defined processes and actions for all levels of doctors, nurses and non-clinical staff when responding to a patient and/or their carer's concerns, particularly when the patient/carer is distressed and/or in crisis and/or are reporting an increase in symptoms and/or deterioration.

3. The active prevention of misdiagnosis/misinformation given to carer's and/or patients by nurses and non-clinical staff through the introduction and enforcement of policies which prohibit suggestions or comments about possible diagnosis so that carers and consumers are not misled or given a potentially dangerous impression.

4. Processes that ensure that upon a patient's presentation and/or admittance to a SA Health hospital or public health site that they or their carer are given clear and written information on:
   - Their rights and responsibilitie,s including that they have the right to receive a discharge summary prior to discharge, the right to ask questions and receive adequate responses and the right to ask for and receive information.
   - What to expect when they present to a hospital e.g. how will clinicians interact with them, where can they get help, what information they will receive, how do they get help
   - How to initiate an escalation process.

5. The introduction of policies and processes to SA Health/Country Health EDs that requires all levels of nurses, doctors and on-call GP's to consult with patients and carers during their assessment, observations, examination, treatment decisions, possible diagnosis, risk levels and ongoing care requirements and which takes account the patient and carer's concerns and observations, inclusive of questions around how the patient usually presents.

6. The introduction within SA Health/Country Health EDs of definitive communication processes between treating health professionals internally and externally (inclusive of other public or private hospitals, GPs, nurses, allied health and specialists) that aim to ensure essential patient and carer information is handed over, communicated and easily accessible as soon as possible to all that have significantly interacted with or been involved in a patient's care.

7. The introduction of strict guidelines within SA Health/Country Health EDs that ensure all clinical staff record their observations, diagnosis etc. on a patient's file in a timely manner so that they are ready for handover internally and externally.

8. The mandatory review and consideration of all documentation (history, observations, case notes, examinations, tests, referrals, discharge summaries) before a decision to discharge a patient from an SA Health/Country Health ED is made by a treating and/or supervising doctor or consultant, particularly for patients assessed as triage Level 1 and 2.

9. The introduction of policies and measures e.g. clear, prominent, and accurate signage, information distributed at GP surgeries, online, media (radio, print) announcements, which aims to advise country consumers what their best course of action is in an emergency given the current utilisation of skeleton staff and on call doctors within Country Health Emergency Departments and which takes into consideration the following factors:
    - The hospital's capacity to respond to and treat serious and life threatening.
    - Proximity to paramedics
    - Ease of access to consultants, specialists, doctors in the context of the hospital's or health services proximity to city based hospitals and services.
    - Ratio of doctors and nurses to inpatients.
    - Appropriateness of expertise available given the surrounding demographics e.g. age, population, vulnerable groups (e.g. elderly, youth, ATOD, mentally ill, Aboriginal and CALD groups).
    - Capacity to provide ongoing treatment for common diseases e.g. cancer, diabetes, particularly in relation to paediatrics.