[2021] WACOR 40

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	19 - 20 May 2021
DELIVERED	**:**	29 NOVEMBER 2021
FILE NO/S	**:**	CORC 68 of 2016
DECEASED	**:**	Miss T

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Tyler assisted the Coroner.
Mr J Berson & Mr K Sardinha (SSO) appeared for the WA Country Health Service and the Department of Communities.
Mr T Palmer appeared for Dr Yen Long Teoh.
Ms A Barter & Ms E Langoulant (ALS) appeared for the family of Miss T.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Miss T*** *(name suppressed) with an inquest held at Kalgoorlie Courthouse, Court 2, 208 Hannan Street, KALGOORLIE, on 19 May 2021 to 20 May 2021, find that the identity of the deceased person was* ***Miss T*** *and that death occurred on 25 December 2016 at Unit 3, 55 Millen Street, Boulder, from acute abdominal obstruction secondary to adhesions associated with severe pelvic inflammatory disease in the following circumstances:*

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SUPPRESSION ORDER

The deceased's name is suppressed from publication. The deceased should be referred to as 'Miss T' in any external publication and no information should be published that might lead to the identification of the deceased.

INTRODUCTION

1. Miss T was a young Aboriginal woman who died in Kalgoorlie on Christmas Day 2016 from an acute abdominal obstruction secondary to complications of severe pelvic inflammatory disease (associated with a sexually transmitted disease). She was only 16 years of age.

2. Miss T had been taken by ambulance to Kalgoorlie Regional Hospital the night before she died with severe abdominal pain and vomiting. Early investigations showed signs of a bacterial infection, but these results were attributed to dehydration and infection does not appear to have been considered. Miss T was discharged home that same day with no clear diagnosis and a referral to see her general practitioner, even though it was the Christmas period and most GP practices would be closed. She died at home on Christmas Day, less than 12 hours after she was discharged.

3. Unfortunately, the coronial investigation took an unusually long time to be completed and reviewed. It was not referred to the Kalgoorlie Coroner by police until July 2019 due to some confusion about the availability of the toxicology results. Following the provision of the police investigation report in July 2019, the case was promptly referred to the Perth Coroner's Court to consider the matter further as to whether an inquest hearing should be held.

4. Further investigations at the Perth Coroner's Court, including an expert review by an Emergency Medicine Consultant, Dr Thomas Hitchcock, led me to decide that it was desirable to hold an inquest to investigate further the circumstances of Miss T's death and whether her death was preventable.

5. I held an inquest at the Kalgoorlie Courthouse on 19 and 20 May 2021. The inquest considered the adequacy of the care that was provided to Miss T at Kalgoorlie Hospital, prior to her death, as well as more general issues in relation to the identification and management of sepsis and sexually transmitted diseases. This was particularly so in relation to young Aboriginal people, who have sadly been identified as at increased risk of sexually transmitted diseases and the complications that can then arise if they are left untreated.

6. Further, consideration was also given to the contact between Miss T and the Department of Communities, and whether more could have been done by that Department to intervene or offer support to Miss T prior to her death, even though she was not in State care.

BACKGROUND - COMMUNITIES' CONTACT

7. Miss T was one of four children born to her mother and her father. She also had three half-siblings. Miss T first came to the attention of the Department of Communities (Communities) in June 2001 when her mother sought financial assistance for her children, including Miss T. Financial assistance was provided on that occasion, and on many other occasions over the years.[1]

[1] Exhibit 1, Tab 26A.

8. There were multiple allegations of domestic violence between Miss T's mother and father over the years, many of which led to police attendance. This had led to allegations of neglect of Miss T and her siblings being reported by police to Communities a number of times in 2006 after the police attended their home for other matters. Concerns were raised that their home was unhygienic and they were being exposed to physical violence perpetrated by Miss T's father against her mother. On each of these occasions, Communities recorded these concerns as an Interaction, which is an electronic record of the referral, the details of the contact, and an initial assessment of the referral. On each occasion, following these referrals, Communities determined that they would take no further action.[2]

9. On 17 August 2006, following another report by Coolgardie police to Communities expressing concern, a Safety and Wellbeing Assessment was commenced by Communities' staff and harm was substantiated. However, it appears that the concerns were considered resolved as there had been a brief period of Intensive Family Support during the investigation, although that support also ended at the resolution of the investigation.[3]

10. More reports of possible neglect, and requests for financial assistance, occurred in 2007 and 2008. On 24 December 2008 another Safety and Wellbeing Assessment was commenced following a report by police to Communities that Miss T and a sibling had disclosed to a friend that they were being sexually abused by men at their home. Communities' staff interviewed Miss T and her sister at the Coolgardie Police Station on 31 December 2008. Following the interviews it was concluded that the harm had not been substantiated.[4]

11. On 23 April 2009 Coolgardie police raised further concerns with Communities about possible emotional harm and neglect in relation to Miss T and her sister. However, after a brief inquiry, on 10 June 2009 Communities determined that no further action was required.[5]

12. Communities assisted with financial assistance requests from Miss T's mother in late 2009 and then another Safety and Wellbeing Assessment was commenced on 24 November 2009. The assessment was initiated after Coolgardie police reported emotional harm and neglect concerns for Miss T and her siblings, due to family and domestic violence in the home, as well as the children being left to walk the street after dark without supervision and being left to fend for themselves. It was determined by Communities that there was no evidence the children had been harmed as a result of the domestic violence. Further, it was noted Miss T's mother and the children had relocated to Esperance around that time. A period of Family Support was commenced but the case was eventually closed in January 2011.[6]

[2] Exhibit 1, Tab 26A.
[3] Exhibit 1, Tab 26A.
[4] Exhibit 1, Tab 26A.
[5] Exhibit 1, Tab 26A.
[6] Exhibit 1, Tab 26A.

13. On 15 February 2011 Esperance police contacted the Communities' Crisis Care Unit (CCU) as Miss T's family had been evicted from their accommodation. It appears they had been living with a grandparent, but due to the behaviour of Miss T's father they were asked to leave. Emergency accommodation was provided and the evidence indicates they then made their way back to Kalgoorlie, and then down to Perth. They eventually returned to Esperance in April 2012 with financial assistance from Communities.[7]

14. In August 2012 Esperance Police referred Miss T's mother, with her consent, to the Communities' Goldfields District Office for Parental Support. There were issues with Miss T and her sister being involved in antisocial behaviour at their primary school and the Deputy Principal had raised concerns about their mother's inability to manage their behaviour.[8]

15. In November 2012 Communities' CCU was contacted by a social worker from Royal Perth Hospital as Miss T's mother had been admitted for dehydration due to a virus and the family were having accommodation issues after travelling to Perth for a funeral. Miss T's family were given assistance for temporary accommodation and food.[9]

16. Another Parent Support referral was made in January 2013 after the earlier one lapsed. There appeared to have been continuing issues with the children's behaviour, as on 13 November 2013 the Department of Housing contacted Communities due to disruptive behaviour by children at the property where Miss T and her siblings were living.[10]

17. After this time, Miss T appears to have left Kalgoorlie and headed to Perth, where she was living on her own, even though she was only in her early teens. On 31 December 2013 Communities received a report that Miss T was homeless and was seen alone at the Burswood Train Station. Attempts to locate her were unsuccessful.

18. On 8 February 2014 Miss T was again reported being alone at a train station in Perth. She was apprehended by police and taken to the 'Youth At Risk' Strategy Facility as she presented as intoxicated and agitated. She refused to engage with staff there and eventually she was taken to the Cannington Police Station. She was held as a 'drunk detainee', having been found to have a blood alcohol level of 0.1%, until her aunt was able to come and collect her.[11] Communities' CCU consulted with the Aboriginal Practice Leader and a decision was made to bring Miss T into the provisional care of the Communities' CEO under s 37 of the Act and refer her to a placement service.[12]

[7] Exhibit 1, Tab 26A.
[8] Exhibit 1, Tab 26A.
[9] Exhibit 1, Tab 26A.
[10] Exhibit 1, Tab 26A.
[11] Exhibit 1, Tab 26A.
[12] Exhibit 1, Tab 26A.

19. The next day, being 9 February 2014, Communities' staff conducted a home visit to Miss T at her aunt's home and her matter was progressed to a Safety and Wellbeing Assessment. Harm was substantiated at that time, but the matter was considered resolved, and the period of provisional protection and care ceased, after she was returned to her parents' care on 19 February 2014.[13] Despite this recorded outcome, she was placed on an alert by Communities' Cannington District on 26 February 2014 as she was considered to be transient.[14]

20. On 2 March 2014, Communities' CCU received a report of concern for Miss T following a disclosure that she had consensual sex with a 14 year old male. It was noted that Miss T had undergone screening for sexually transmitted infection, with results pending. No report was later received from the Department of Health to indicate a positive result, so it is assumed that her screening results at that time were negative.[15]

21. Communities' CCU completed an intake for sexual harm to commence an initial inquiry. On 6 March 2014 this was escalated to a Safety and Wellbeing Assessment, but in the end no sexual harm was substantiated. The matter was also referred to the WA Police, but no charges appear to have arisen.[16]

22. On 7 March 2014 Communities' Cannington District wrote to Swan View Senior High School to arrange for Miss T's enrolment. She was living with her aunty at that time. Communities advised Youth Justice that Miss T was sexually active and it was agreed that they would speak to Miss T about underage sex. It seems that there was also a plan for Miss T to be interviewed by Communities' interview unit about sexual activity but there is no record of this occurring. The Communities' Cannington District team closed its case for Miss T on 11 March 2014.[17]

23. On 21 March 2014 WA Police apprehended Miss T in Perth as she was out without a responsible adult. She told police she had left her aunt's house on 14 March 2014. Miss T was again taken to the 'Youth At Risk' Strategy Facility. She was kept there while Communities' CCU contacted Miss T's aunt, who agreed to care for Miss T for the weekend until she could be assisted to return to her family in Kalgoorlie/Coolgardie. Miss T was assisted to return to Coolgardie to live with her older sister.[18]

24. On 3 July 2014 WA Police emailed a referral for Miss T and her older sister to the Communities' Midwest Gascoyne District due to Miss T's non-attendance at school and escalating criminal behaviours. It was noted that Miss T had recently moved to Geraldton and had allegedly committed a number of serious offences. Communities completed an intake to Parent Support and the case was allocated on 24 August 2014.[19]

[13] Exhibit 1, Tab 26A.
[14] Exhibit 1, Tab 26A.
[15] Exhibit 1, Tab 26A.
[16] Exhibit 1, Tab 26A.
[17] Exhibit 1, Tab 26A.
[18] Exhibit 1, Tab 26A.
[19] Exhibit 1, Tab 26A.

25. On 27 October 2014 Miss T appeared in the Children's Court and was bailed to her grandmother's address.[20] The next day, the Youth Intervention Crime Officer from WA Police advised Communities' Geraldton Office that a known sex offender was recorded to reside at the bail address and another known sex offender was known to frequent that address. An agreement was reached for someone to conduct a home visit to speak to Miss T's sister and discuss the concerns about the bail address. After this discussion, WA Police agreed to conduct a home visit at the grandmother's address to discuss the safety concerns and determine what safety plans were in place. It appears the concerns were resolved, as the matter was ended on 30 October 2014 with no further action taken.[21]

26. WA Police emailed another referral to Communities on 30 December 2014 due to Miss T's offending behaviour, non-compliance with Juvenile Justice Orders, non-attendance at school and concerns her family were at risk of homelessness. A month later, on 24 January 2015, Miss T had made her way to Perth by bus with a cousin and was apprehended by police in the Perth CBD without a responsible adult. Miss T's mother was notified. She was upset as Miss T had travelled to Perth without her knowledge. Miss T's mother made suggestions about family members who could be approached to care for her in Perth. Appropriate arrangements were made for Miss T to go to the home of one of these family members.[22]

27. On 30 May 2016 there was a concerning allegation that Miss T had stabbed her younger sister in the back with a pair of scissors the previous day. Enquiries were made with family members where Miss T was living and concerns were raised about Miss T's mental health. It was indicated that her family were intending to source counselling for Miss T through Corrective Services. She was apprehended on her own in Perth CBD again on 11 June 2016 and was transported home to her family by Nyoongar Outreach Services.[23]

28. According to medical records[24], Miss T travelled from Geraldton to Kalgoorlie to stay with her father in September 2016. While it is not entirely clear, it appears Miss T lived a relatively transient life, staying with different family members in Geraldton and Kalgoorlie between June 2016 and December 2016.

FIRST PRESENTATION TO HOSPITAL – 10.12. 2016

29. On 10 December 2016 WA Police attended a residence in Kalgoorlie after Miss T phoned police and reported that her father had assaulted her. It was treated seriously by police as a reported family and domestic violence incident. Miss T was found lying on the couch holding her stomach. She told the attending officers that her father had pushed her and sat on her. She had no visible injuries but complained of pain in her ribs, chest and stomach. Sergeant Jaime Forbes, who was one of the attending

[20] Exhibit 1, Tab 26A.
[21] Exhibit 1, Tab 26A.
[22] Exhibit 1, Tab 26A.
[23] Exhibit 1, Tab 26A.
[24] Exhibit 1, Tab 23B.

officers and was a Senior Constable at that time, recalled Ms T was having difficulty speaking due to the level of pain.[25]

30. Miss T was transported by the police officers to Kalgoorlie Hospital for medical assessment.[26] The police officers noted Miss T was hunched over, could not stand up straight and appeared to be in considerable pain when they arrived at the hospital.[27] The police officers left Miss T in the care of medical staff and asked to be called once she had been treated so that they could talk to her a bit more about the assault, as well as ensuring she got home safely.[28]

31. Miss T was seen immediately upon arrival at 4.49 pm. Registered Nurse Amy Fisher was the triage nurse on duty in the Emergency Department at Kalgoorlie Hospital at that time. At the inquest, Nurse Fisher indicated she did not have an independent recollection of seeing Miss T that day (which is not unusual given the volume of patients she saw over time) but she relied upon her contemporaneous notes made during the triage assessment and her knowledge of her usual practices. Nurse Fisher made a triage assessment of Miss T and took some vital observations. Nurse Fisher said this process would have taken between three and five minutes. Nurse Fisher explained that in terms of information obtained from a patient at the time of triage, they would ask the patient why they were presenting to the ED. The triage nurse would rarely ask for the patient's medical history, other than relevant medical history.[29]

32. The triage form recorded that Miss T had been brought in by police after being assaulted by her father, who had sat on her chest and started punching her in the ribs and head. She denied losing consciousness and stated that she had pain throughout her abdomen and that it felt hard to breathe. She was noted to be hunched over at the time of triage but was speaking in full sentences and had 100% oxygen saturations on room air. Her dehydration status was recorded as normal and she gave a pain score of 4/10 according to Nurse Fisher, although it appeared like 7/10 on the triage form due to an error. All her vital observations were within normal range. Miss T was given a triage score of 4 (indicating she should be seen by a doctor within one hour) but was still moved straight into a cubicle rather than being sent back to the waiting area. Miss T was moved into the cubicle at 5.00 pm and a primary health nurse took over her care from that time.[30]

33. In the nursing notes, Miss T was recorded at 5.00 pm to be moaning in pain, guarding her stomach and demanding she receive help straight away. She was examined by Dr Wei Shearn Poh shortly after at 5.10 pm, under the supervision of the ED Consultant. When speaking to Dr Poh, Miss T stated her head had been 'split open' in the assault but denied any loss of consciousness, nausea or vomiting. She had a small superficial laceration to the left side of her head, consistent with the description of an assault to her head. Miss T rated her pain as 10/10 and constant at

[25] T 8; Exhibit 1, Tab 20 and Tab 26A.
[26] Exhibit 1, Tab 20 and Tab 26A.
[27] Exhibit 1, Tab 20.
[28] T 9; Exhibit 1, Tab 20.
[29] T 19 - 20; Exhibit 1, Tab 23A, Triage Form, 10.12.2015 and Tab 28.
[30] T 21 - 23; Exhibit 1, Tab 23A, Triage Form, 10.12.2016 and Tab 28.

that time, but Dr Poh noted that Miss T had "distractible tenderness," meaning she would tense her stomach muscles when he examined them, but would reduce or stop tensing them when distracted. Dr Poh explained that this feature can indicate that a patient's pain is of lower severity than reported.[31]

34. Dr Poh indicated that his primary concern, given the allegation of assault and report of abdominal pain, was to assess Miss T for any kind of organ damage. For that purpose, Miss T had a FAST (Focused Assessment with Sonography for Trauma) ultrasound scan performed, to look for any significant fluid collection within the abdomen suggestive of internal bleeding. No fluid was detected. It was also intended to perform a urinalysis and urine drug screen, but it appears from the nursing notes that she was unable to provide a urine sample.[32]

35. Miss T was also given Panadeine Forte for her pain, with the plan that if her pain did not improve, an abdominal x-ray or CT scan might be performed as the FAST ultrasound does not rule out major solid organ injuries or minor bleeds. Dr Poh explained that a CT scan was not done immediately, as Miss T was only 16 years old and it is standard practice to limit a young person's exposure to radiation and do it only where necessary.[33]

36. Miss T was discharged at 8.21 pm with a plan to give her some pain relief to take with her and advice to return to the ED if her symptoms worsened.[34]

37. The police were told at about 9.00 pm that Miss T was ready to be discharged. Sergeant Forbes and his partner returned to the hospital to collect Miss T. Miss T still appeared to the police officers to be in considerable pain. She was unable to tell them what was wrong with her or what treatment she had received but Sergeant Forbes recalled that Miss T thought it was just bruising. The police officers assisted her into the police car due to her obvious pain. Sergeant Forbes gave evidence that, looking back, he recalled being concerned that she was quite sick but there was not a lot, personally, that he could have done differently.[35]

38. They considered there was no way they could take a statement from Miss T in relation to the assault at that stage, given her obvious discomfort, so they simply took her to an address she gave them.[36] Miss T was taken to her neighbour's house. The police officers noted she had to be assisted into the house by her friend, Shalia Higgins.[37]

39. The police officers were aware Miss T had an outstanding arrest warrant, but they sensibly decided it was not appropriate in the circumstances to take action on it at that time.[38]

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[31] T 48 – 50; Exhibit 1, Tab 23A, ED Continuation Notes, 10.12.2016 and Tab 27.
[32] Exhibit 1, Tab 23A, ED Notes, 10.12.2016 and Tab 27.
[33] T 51 – 52; Exhibit 1, Tab 23A, ED Continuation Notes, 10.12.2016 and Tab 27.
[34] T 53;
[35] T 13; Exhibit 1, Tab 20.
[36] Exhibit 1, Tab 10 and Tab 20.
[37] Exhibit 1, Tab 10 and Tab 26A.
[38] Exhibit 1, Tab 26A and Tab 26B.

EVENTS AFTER DISCHARGE

40. Miss T had agreed to attend the police station the following day to make a statement as she was too tired and uncomfortable to do so that night. She spoke to the police the next day, but was reluctant to provide a statement. Despite follow up by police, which was difficult as Miss T was hard to locate, she never provided one.[39]

41. Police were unable to locate Miss T's father the night of the alleged assault. Miss T's father was spoken to by police a few days later and he denied assaulting her. He claimed her injuries had been caused when she was 'mobbed' by some girls a few days earlier. Given Miss T declined to provide a statement and he denied any misconduct, no charges were laid against Miss T's father.[40]

42. The police also put through a family violence report to the Department of Communities immediately.[41]

43. On 13 December 2016 (following the weekend), Communities' Family and Domestic Violence Response Team were notified of the incident and they held a triage meeting and referred the matter to the Goldfields District for further assessment. On the same day, the Goldfields District completed an intake for Miss T to undergo a Safety and Wellbeing Assessment for physical abuse concerns.[42]

44. Also on 13 December 2016, the Kalgoorlie Communities' Office attempted an unannounced visit to Miss T's home. Miss T's father was present and he claimed that Miss T had been 'jumped' by a bunch of girls that weekend. She was not at home and he suggested she was at another unit nearby, but no one answered the door at that residence. Kalgoorlie office staff contacted Kalgoorlie Police seeking more information regarding the incident and whether the police knew her current living arrangements.[43]

45. Police rang the Kalgoorlie Communities' office the next day and advised that they had spoken to Miss T's father, who had denied the assault and again claimed her injuries were from an assault by a group of girls. He advised that Miss T was staying either with him or a couple of other places.[44]

46. Unsuccessful attempts were made on 15 December 2016 by Communities' staff to locate Miss T and they left a card for her to contact them. They also made further enquiries through the WA Police.[45]

47. On about 18 December 2016, Miss T ran into her older sister, who had been looking for her as she hadn't seen her for a week or so and was concerned about her. Miss T told her sister she had just got out of hospital. Miss T gave an account of being in a fight with a girl in the street, which wasn't too serious, but she had then been

[39] T 11 - 12; Exhibit 1, Tab 10, Tab 20 and Tab 26A.
[40] T 12 – 13 ; Exhibit 1, Tab 10 and Tab 20.
[41] T 10 – 11.
[42] Exhibit 1, Tab 26A.
[43] Exhibit 1, Tab 26A.
[44] Exhibit 1, Tab 26A.
[45] Exhibit 1, Tab 26A.

involved in an incident with her father, during which he assaulted her by forcing her onto the ground with his knee on her stomach and put his hands around her neck. Miss T told her sister when he put his knee into her stomach it had really hurt and due to her stomach pain, she had gone to hospital. Miss T said the police were aware of the incident and her father had been avoiding her since the fight. Miss T stayed with her sister that night, and then left.[46]

BEGA GARNBIRRINGU CONSULTATION – 15.12.2006

48. It appears that Miss T went to Bega Garnbirringu Health Services (Bega Health) when she needed to see a GP in Kalgoorlie. Bega Health is an Aboriginal Community Controlled Health Organisation that provides culturally appropriate, holistic health care services in the Goldfields region. The Bega Health medical records show Miss T was seen on seven occasions between 2004 and 2013 for common, minor medical issues such as an ear infection and chicken pox. She was not known to have been diagnosed with any chronic medical conditions.[47]

49. On 15 December 2016, Miss T attended Bega Health Service with a number of complaints. She was initially seen by a nurse, who documented her presenting issues as:[48]
    - Meningococcal vaccine;
    - Injuries to her ribs and back due to an assault by her father on 11 December 2016;
    - Vaginal discharge yellow/brown since Monday (12 December 2016) – last period last year due to Implanon (contraceptive implant); and
    - Removal of Implanon and new Implanon insertion.[49]

50. Miss T's vital observations were recorded, which showed she was quite underweight, with a BMI of 14.8. Some of her readings, such as her temperature, were normal, but there were leucocytes in her urine analysis (as was the case when she presented to hospital a couple of weeks later), which can be a sign of infection.[50]

51. Miss T was administered the meningococcal vaccine by another nurse and she was then reviewed by a GP, Dr Moe-Sani Aye. Dr Aye documented that Miss T had presented to Kalgoorlie Hospital ED on 10 December 2016 after an alleged assault by her father and that the ultrasound scan had shown no free fluid, her urine analysis had been normal and she was discharged.[51]

52. Dr Aye sought to take a more detailed history from Miss T, but indicated that Miss T was not able to provide an accurate and proper history. Therefore, at the doctor's request, she signed a form to allow the health service to request a copy of her medical information, including the date of insertion of the Implanon from a clinic in

[46] Exhibit 1, Tab 9.
[47] Exhibit 1, Tab 23B.
[48] Exhibit 1, Tab 23B.
[49] Exhibit 1, Tab 23B.
[50] Exhibit 1, Tab 23B.
[51] Exhibit 1, Tab 23B.

Geraldton and the discharge summary from the presentation to Kalgoorlie Hospital on 10 December 2016.

53. Dr Aye indicated Miss T had a large number of presenting issues, that could not all be managed by a GP at one consultation. Based upon the information about the hospital presentation arising from an alleged assault by her father, and Miss T still complaining of pain in her chest and abdomen, Dr Aye prioritised this issue in her assessment of Miss T that day. She performed an assessment with "priority to rule out acute life threatening medical, surgical conditions and acute crisis of mental health."[52] Dr Aye considered it important, given the family and domestic violence aspect, to also ensure that Miss T had safe accommodation. Miss T told Dr Aye she was afraid to go back home and she had made plans to stay at her cousin's place. With Miss T's consent, Dr Aye discussed with an Aboriginal Health Practitioner, Loretta, Miss T's accommodation situation. Loretta confirmed that Miss T would stay at her cousin's place and was planning to go back to Geraldton when she received a payment on the Monday.[53]

54. It was noted that Miss T was still experiencing pain on and off in her 'tummy and chest' and she wanted pain relief medications. She indicated that she smoked marijuana almost every day, including the day before, and drank alcohol, although she was under 18 years of age. She denied any thoughts of suicide or self-harm. Of note, Miss T was afebrile (not feverish) and looked well. Her chest was clear and her blood pressure was rechecked and was normal, as was her heart rate. Her abdomen was soft and non-tender, although some voluntary guarding was noted. Dr Aye considered her urine screen to be normal. Dr Aye's impression at the time was musculoskeletal pain due to the recent assault.[54]

55. Miss T declined a urine drug screen and also declined a referral to Hope Service, which is a drug and alcohol service. She was given a script for analgesia to manage her pain, as requested. Dr Aye also discussed with Miss T red flag symptoms of fever, vomiting, drowsiness, chest pain, shortness of breath and abdominal pain, and told Miss T to present to the emergency department of Kalgoorlie Hospital if any of those symptoms occurred or her condition got worse.

56. In relation to the other issues Miss T raised, including the vaginal discharge, Dr Aye perceived them to be non-life-threatening medical complaints and she advised Miss T to return to the clinic for follow up the following day. Dr Aye planned to then address the concerns of the vaginal discharge and removal of the Implanon. Dr Aye expected to have the information from the Geraldton clinic by then, in relation to the Implanon insertion, and was also hopeful to have established a better rapport with Miss T by then, which would "allow an open discussion about her women's issues."[55] Unfortunately, Miss T did not reattend the clinic the next day, and did not return to the clinic prior to her death.

[52] Exhibit 2B.
[53] Exhibit 2A.
[54] Exhibit 1, Tab 23B; Exhibit 2A - 2B.
[55] Exhibit 2B.

57. Dr Aye indicated in a report she provided to the Court that, at the time she reviewed Miss T on 15 June 2016, she noted no features of sepsis (identified as fever, tachycardia, hypotension and lethargy). There were also no features of dehydration.[56]

58. A new vaginal discharge could raise suspicion of an STD, if it was known that Miss T was sexually active (which was strongly suggested by her use of Implanon, a contraceptive implant). In Miss T's case, she also complained of abdominal pain and her urine analysis detected protein and leucocytes (white cells), which further supported a possible diagnosis of STD. These issues would, no doubt, have been given greater consideration and attention if Miss T had returned to the clinic the next day, as suggested, so that her complaint of vaginal discharge and the question of overdue Implanon could be explored. Unfortunately, Dr Aye focussed upon what she considered to be the more urgent concern at the first visit, which is understandable in the circumstances, and there was no second visit.

59. As a result, an opportunity to diagnose and treat the gonorrhoea infection, that ultimately caused Miss T's death, was lost.

60. I am advised that in the past 12 to 24 months some significant improvements have been made to the Bega Health Service, including the employment of a dedicated sexual health nurse and an ability to now perform onsite testing via the Point of Care units enabling the service to test for the sexually transmitted infections Syphilis, Trichomonas, Chlamydia and Gonorrhoea.[57] It is possible that the availability of the nurse and on site testing might have enabled Miss T to be dealt with for her Implanon and vaginal discharge complaints on the same day she was assessed by Dr Aye for the other presenting complaints, rather than requiring two visits. They are, therefore, positive changes from the perspective of this inquest and its tragic outcome for a young Aboriginal woman with an undiagnosed STI.

LEAD UP TO NEXT HOSPITAL PRESENTATION

61. On 22 December 2016 Communities' Kalgoorlie office attempted an unannounced visit at the units in Duggan Street were Miss T was believed to be staying and they were told she was in Millen Street. They went to the home in Millen Street and were told by the residents that Miss T was indeed living there, but she had just left. The Communities' staff advised Miss T was not in trouble and they were only concerned for her welfare. They left a card and requested the occupants to ask Miss T to call them. They were unable to make contact with her before she died a few days later.[58]

62. According to Miss T's older sister, Miss T returned to her house on Thursday, 22 December 2016, although it would appear from later events that she was probably referring to Friday, 23 December 2016. Her sister recalled Miss T seemed pale, very skinny and gaunt, with her ribs and cheek bones showing. She also appeared quite weak and indicated she was in a lot of pain from cramps in her belly. Her sister noted

[56] Exhibit 2A.
[57] Exhibit 2C.
[58] Exhibit 1, Tab 26A.

Miss T was holding her belly when walking. She ate some of her sister's takeaway food but her sister didn't see her eat anything else.[59]

63. Miss T's sister offered to get her some painkillers, but she declined as she said the doctors had already given her some, but she didn't like them and had thrown them out. That night she slept at her sister's house. Her sister recalled Miss T called out often for water during the night.[60]

64. The next morning, which appears to have been the morning of 24 December 2016, Miss T's sister noticed that Miss T had vomited all around the sides of her bed during the night. The vomit was yellow in colour and appeared to be just liquid. She rang for an ambulance to take Miss T to hospital as she was concerned about her. An ambulance was allocated the task at 8.45 am and arrived soon after. The St John Ambulance Patient Care Record records that Miss T's pulse was rapid, her blood pressure was normal and her pain scale was high due to abdominal pain. She declined pain medication and was recorded as walking by herself to the ambulance, although her sister recalls that she had to help Miss T walk to the ambulance.[61]

SECOND PRESENTATION TO HOSPITAL – 24.12.2016

65. Miss T arrived by ambulance at the Kalgoorlie Hospital ED at 9.12 am on 24 December 2016. She was triaged again by Nurse Fisher, who assessed her immediately upon her arrival. A pulse of 113 was recorded and she told Nurse Fisher a history of right sided abdominal pain ongoing for two days with vomiting but no diarrhoea (although a later nursing note made at 10.30 am indicates a history of diarrhoea). It was noted Miss T had been in the ED with similar complaints one week prior. Nurse Fisher did not have access to Miss T's medical notes from her previous presentation on 10 December 2016 in her role as triage nurse so she simply recorded the history of one week, as presumably told to her by Miss T. Miss T's alert pain score was 8/10 on arrival. Nurse Fisher gave Miss T a triage score of 3, indicating she needed to be seen within 30 minutes. This seemed to suggest that, despite her pain score, Miss T appeared sufficiently comfortable to wait for half an hour to be seen by a doctor.[62] As occurred at the earlier presentation, Miss T was taken quickly from triage into a cubicle.

66. It was noted that, unlike on the previous presentation, no dehydration score was done for Miss T. Nurse Fisher was not sure why she didn't do one on this occasion. She suggested it may have been because she was busy or forgot or there were no stickers available at the time, as well as noting that the score is more of a useful tool for children and not something necessarily done routinely for teenagers.[63]

67. Dr Imadelin Hamid was working as a Resident Medical Officer at Kalgoorlie Hospital at this time as part of a workplace based assessment program in order to

[59] Exhibit 1, Tab 9.
[60] Exhibit 1, Tab 9.
[61] Exhibit 1, Tab 9, Tab 15 and Tab 16.
[62] T 29, 34 – 35, 40; Exhibit 1, Tab 23A, Triage Form, 10.12.2016 and Tab 28.
[63] T 33.

become registered as a medical practitioner in Australia. Before that time, Dr Hamid had been practising as a medical practitioner in Sudan and Saudi Arabia for many years, and in Australia since 2014, so despite his RMO status at that time, he was an experienced medical practitioner. However, working in the role of a junior doctor at the hospital, he was required to be supervised by a more senior doctor.[64]

68. Dr Hamid reviewed Miss T at around 10.00 am and he estimated he spent around half an hour reviewing Miss T. Dr Hamid had some limited independent recollection of his review of Miss T, but largely relied upon his contemporaneous notes as to the details of what occurred.[65]

69. Dr Hamid recorded that when he first reviewed Miss T, she reported she had been suffering abdominal pain and vomiting since the previous day with minimal diarrhoea. She had vomited continuously and denied any food or alcohol being the cause. She did admit to smoking marijuana the previous night and using intravenous drugs recently. Her venous blood gas results done at that time showed slightly raised pH, low pCo2, low calcium, raised glucose and raised lactate. Dr Hamid gave evidence he attributed the results to Miss T's history of vomiting and losing fluids. In response, a cannula was inserted and Miss T was given fluids and medication for nausea. She was also given Panadeine Forte for pain relief.[66]

70. An ECG, undated and not time stamped, but believed to have been taken around 10.19 am, shows a sinus tachycardia of 120/min and a number of electronically reported abnormalities, which are non-specific.[67]

71. A nurse entry at 10.30 am recorded Miss T appeared alert and orientated at that time and still felt nauseous but had not vomited since arriving at the ED.[68]

72. An entry at 11.00 am recorded that Miss T was still nauseous and a further dose of medication for nausea was given at 11.14 am. She still had not been able to provide a urine sample at that stage.[69]

73. Miss T was able to provide a urine sample at 12.37 pm, which tested positive for opioids, THC, methylamphetamine and amphetamine. Her doctor was informed.[70]

74. Dr Hamid made another entry in the medical notes, reflecting his further interaction with Miss T, at 1.37 pm, although it would seem he saw her some time earlier. Dr Hamid was not sure if Miss T's urinalysis results had come through at this time, and whether or not he was the doctor that was informed, as per the nursing note.[71]

[64] T 64 – 66, 92 - 95; Exhibit 1, Tab 34.
[65] T 65; Exhibit 1, Tab 34.
[66] T 70 – 72; Exhibit 1, Tab 23A, ED Continuation Notes, Note 1, 24.12.2016.
[67] Exhibit 1, Tab 21.
[68] Exhibit 1, Tab 23A.
[69] Exhibit 1, Tab 23A.
[70] Exhibit 1, Tab 23A.
[71] Exhibit 1, Tab 23A and Tab 34.

75. Dr Hamid's entry recorded at 1.37 pm was that he had seen Miss T with the ED Consultant on duty, Dr Yen Teoh.[72] Miss T said her pain had been 9/10 on admission. She was dehydrated, afebrile (not feverish) and anxious and it was difficult to perform an examination on her, although it was also noted she was not distressed. Miss T had a tachycardia (fast heart rate) of 130 and she had apparently vomited several times in ED by this time. All her other observations were within normal limits. On examination her chest was clear, heart sounds were normal and her abdomen was soft, with noted epigastric tenderness but no guarding or rigidity. Dr Hamid recalled that Miss T was not very cooperative and a poor historian when he was reviewing her, and the poor communication complicated the assessment.[73]

76. Dr Hamid gave evidence that after reviewing Miss T for the second time, Dr Teoh had told him to go and see another patient and Dr Teoh then took over Miss T's care. Dr Hamid gave evidence he did not see Miss T again after that time. However, he did later review her blood test results as he was interested to know what was going on and her diagnosis, even though he was no longer responsible for Miss T's treatment in the ED.[74]

77. The last typed entry in the ED Continuation Notes was written by Dr Hamid at 1.44 pm. He gave evidence this was typed after Miss T had been discharged by Dr Teoh. Dr Hamid entered the blood test results, as set out below:[75]

- Beta HCG (pregnancy test) – negative;
- CRP (marker of inflammation/infection – raised - 20 (<10);
- White cell count – raised - 30.2 (normal 4.5 – 13);
- Neutrophils – raised – 27.1 (1.8 – 8);
- Platelets – raised – 974 (150 – 400);
- Urea and sodium levels (which are commonly raised in dehydration) were normal;
- Urine drug screen showed large amounts of ketones and was positive for THC, amphetamines, methamphetamine and opioids.

78. Dr Hamid gave evidence at the inquest that he raised the raised white blood cell count with Dr Teoh, as he was worried about it. Dr Hamid explained that it could reflect sepsis infection, leukaemia or be related to more benign causes, but he thought it was concerning. In the medical notes, Dr Hamid recorded that he discussed leucocytosis with Dr Teoh and that Dr Teoh indicated that due to dehydration this needed to be rechecked by her GP, which is why Dr Hamid made that entry.[76]

79. Dr Hamid gave evidence that if he had been managing Miss T himself he would have repeated the test before she was discharged, but by the time he discussed the results with Dr Teoh and raised his concern, Miss T had already been discharged home and Dr Teoh was not concerned.[77]

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[72] T 73 – 74.
[73] T 80; Exhibit 1, Tab 23A, ED Continuation Notes, Note 2, 24.12.2016.
[74] T 73 – 74, 104; Exhibit 1, Tab 34 [15].
[75] Exhibit 1, Tab 23A, ED Continuation Notes, Note 3, 24.12.2016.
[76] T 76; Exhibit 1, Tab 23A, ED Continuation Notes, Note 3, 24.12.2016.
[77] T 77 - 78.

80. On Dr Teoh's instructions, Dr Hamid also made an entry in the notes that Dr Teoh had re-examined Miss T and she had reported her pain was getting better, she was no longer vomiting and was tolerating oral drinks. Dr Teoh was recorded advising Miss T to return to the ED if she had any concerns, and she was also given advice to quit smoking and that "smoking marijuana can cause abdominal pain."[78]

81. Dr Hamid gave evidence that at the time he reviewed Miss T, earlier that day, no diagnosis had been made. Sepsis, or some other form of infective process, was definitely one of the differential diagnoses he was considering. He agreed that Miss T did not exhibit all the classic signs of sepsis, such as a fever, but he believed she required further monitoring.[79] Dr Hamid agreed that the West Australian Emergency Access Target (WEAT), previously known as the 'four hour rule', where ED doctors are encouraged to ensure 90% of patients spend less than four hours in the ED from arrival to admission, transfer or discharge,[80] did make it hard and put a lot of pressure on doctors to dispose of a patient quickly. He also agreed the availability of a short-stay observation ward at Kalgoorlie Hospital might have assisted in a case like Miss T's, where she did not have a clear diagnosis but would have benefitted from further observation to ensure that she was improving before discharge and she was not deteriorating.[81]

82. I note Miss T was told to return to the ED if she had any concerns and to see her GP for a repeat full blood count in two days.[82] This was despite the fact that the timing of two days would fall on Boxing Day – a public holiday – and it was not clear if she even had a regular GP as there was no GP recorded in the auto-generated ED discharge summary. The discharge summary referred to abdominal pain of an unknown cause, so there was no apparent diagnosis at the time of her discharge.[83]

83. Miss T was also discharged home after a total time in the ED of 3 hours and 42 minutes.[84] This is just within the 'four hour rule' time frame. This is relevant when further consideration is given to Dr Teoh's evidence.

84. Noting that Miss T had been brought in by ambulance, was only 16 years old and had no known family present in the ED, it is also important to note that she appears to have been discharged from the hospital on Christmas Eve with no referral to social work and no attention given to how she was going to get home. It appears that Dr Teoh was unaware that she did not have a family member with her, and believed another staff member would have raised any social concerns like this with him if they were apparent, but this did not occur.

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[78] Exhibit 1, Tab 23A, ED Continuation Notes, Note 3, 24.12.2016.
[79] T 79.
[80] T 190.
[81] T 82 – 84.
[82] Exhibit 1, Tab 21.
[83] Exhibit 1, Tab 21.
[84] Exhibit 1, Tab 21.

EVIDENCE OF DR TEOH

85. Dr Teoh is registered to practise in Australia as a specialist emergency medicine physician. Dr Teoh underwent his specialist training in Western Australia. Dr Teoh also has qualifications as a GP Obstetrician and GP Anaesthetist. At the time of these events he was working as a locum Consultant Emergency Physician at Kalgoorlie Health Campus. It was Dr Teoh's first position as a consultant. He was working on a 'fly in, fly out' rotation of approximately 8 days each month. Dr Teoh had considerable previous experience working in regional Western Australia, both in the Kimberley and the Mid-West, as a District Medical Officer, so he was familiar with working in a regional hospital as part of the WA Country Health Service (WACHS). Dr Teoh no longer works as an ED Consultant at Kalgoorlie Hospital, but he does continue to provide GP anaesthetic services there.[85]

86. On 24 December 2016 Dr Teoh was the only consultant rostered on in the Kalgoorlie Hospital Emergency Department. In that role, he was supervising a number of resident medical officers, included RMO Dr Hamid, who first saw Miss T. There was no intermediate level of seniority in the medical staff between the RMO's and the Consultant, so the consultant had to perform a high level of supervision of staff. Dr Teoh had an independent memory of Miss T's case and recalled examining Miss T personally, as well as discussing her case with Dr Hamid.[86]

87. Dr Teoh recalled that Dr Hamid first approached him between 11.00 pm and midnight to discuss Miss T's presentation. He advised that Miss T had presented with pain and vomiting but no history of fevers and nothing to suggest alcohol abuse or food poisoning, although she did admit to recent intravenous drug use. Further, Miss T did not have a fever and her blood pressure was normal but she was tachycardic, which was thought possibly related to dehydration, so he had prescribed her fluids and medication. Her urine test did not reveal nitrites/leucocytes that might otherwise suggest infection, but did indicate cannabis use. Dr Hamid advised there was no focal abnormality on physical examination. Dr Teoh then went to examine Miss T himself.[87]

88. Dr Teoh explained at the inquest that when someone comes to hospital with a complaint of abdominal pain, he makes it a point of examining them himself, which is why he personally examined Miss T. After the examination, he agreed with Dr Hamid in terms of the physical findings, such as her abdomen being soft and there being no clinically acute abdominal signs. Dr Teoh recalled Miss T was reluctant to answer some of the doctors' questions, answering "I don't know" on several occasions. Dr Teoh agreed with Dr Hamid's treatment plan, which included doing blood tests.[88]

89. Dr Teoh gave evidence he examined Miss T a second time after the blood test results were available, because of the abnormality that was shown in the test results, namely an elevated white cell count, in the context of her abdominal pain. Dr Teoh said in

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[85] T 140 – 142; Exhibit 1, Tab 30 [8].
[86] T 142; Exhibit 1, Tab 30.
[87] Exhibit 1, Tab 30 [17] – [23].
[88] T 142 – 143; Exhibit 1, Tab 30 [24].

evidence he examined Miss T the "second time specifically to look for any possibility of infection."[89] At the time of the clinical examination, he could not determine any source of infection, even though he felt he had obtained a better clinical history from Miss T on this occasion.[90]

90. Dr Teoh took the personal history from Miss T without the presence of Dr Hamid. Dr Teoh recalled he sat with Miss T and talked to her about her social situation, as well as her abdominal pain, to try to understand where the pain was coming from and to formulate a diagnosis in view of the abnormal blood tests and her initial presenting complaint.[91]

91. Dr Teoh indicated he did not discuss with Miss T her sexual health history because, from his personal experience with patients who are Indigenous females, she would be more likely to volunteer that kind of relevant information once he established some rapport with her, rather than being asked directly. He did briefly touch upon any possibility of sexual assault, which was "brushed off very quickly"[92] by Miss T, and he decided not to attempt to pursue the topic any further in case it led her to withdraw and decide not to offer any further information to him. At that stage, a sexually transmitted infection was not, in any event, at the forefront of his mind in terms of a diagnosis as her clinical presentation did not indicate any obvious sexually transmitted infection symptoms.[93]

92. Dr Teoh was asked at the inquest whether it would have made a difference if he had been informed that Miss T had recently attended Bega Health Service and reported experiencing a yellow-brown vaginal discharge. Dr Teoh answered that it was hard to say with certainty if it would have made a difference, as the information would need to be considered from the perspective of her presenting complaint, but he believed if Miss T had actually mentioned to him that she had yellow discharge at the time of her presentation, it would have made going into her sexual history of more pressing importance. This could perhaps have led to consideration of a gynaecological cause of her abdominal pain, which might then have led to a gynaecological examination. However, all of this is speculative, as Miss T did not volunteer this information at the time Dr Teoh examined her.[94]

93. Dr Teoh explained that there are a lot of people who come to the ED experiencing abdominal pain and in many of these cases there will be no formal diagnosis. Rather, the doctors will focus on eliminating any of the more sinister diagnoses that might be causing the pain. As part of that process, the doctors will consider whether the pain has settled with treatment in the ED and responded to the initial treatment, which will support the conclusion that the pain is more likely to be coming from a benign cause, even if an exact diagnosis is not made.[95]

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[89] T 143.
[90] T 142 – 143; Exhibit 1, Tab 30.
[91] T 143 - 144.
[92] T 144.
[93] T 144, 165 - 167.
[94] T 146 – 147.
[95] T 143 – 145.

94. This was Dr Teoh's approach in Miss T's case. Dr Teoh gave evidence his initial thought process was to see whether she responded to the treatment of intravenous fluids and medication, and whether her pain then settled. If she did not, there was the option to admit her to monitor her further or discharge her to be monitored at home. Miss T had a quick positive response to the treatment, which reassured him that her abdominal pain was more likely caused by a common benign issue. Early sepsis remained a possibility in his mind, but there was a wide differential diagnosis and it was complicated by her drug use.[96]

95. Dr Teoh stated that he discussed with Miss T that her blood tests were abnormal and they were not able to identify a reason at that stage. Dr Teoh recalled that Miss T did not object to going home at that stage and he was satisfied she understood her clinical condition at that period of time, in the sense that there was an unknown aspect to her diagnosis that required further monitoring. He also understood she would be cared for by family.[97]

96. With the benefit of hindsight, Dr Teoh agreed that Miss T would have benefitted from a longer period of observation in hospital, but at the time he believed she had the capacity to be monitored at home. He understood that her sister (noting she could have used that term to refer to a cousin or friend) would be looking after her.[98]

97. I note this decision was made in the context of a busy hospital ED during the festive period and with the pressure of the 'four hour rule' and a lack of a short stay observation ward, which I will return to later in this finding. Dr Teoh gave evidence the festive period made the ED unusually busy, and that was the case on the night Miss T presented, with many of the medical practices having closed. In addition, there was a high degree of complexity in relation to the patients. Therefore, there was considerable pressure to make quick decisions and keep the movement of patients flowing. Without a clear diagnosis, it was difficult for Dr Teoh to arrange for Miss T to be admitted to a ward, and ultimately he made the decision to discharge her, with a plan for follow up in the community. Dr Teoh gave evidence he was aware of the potential to use an Aboriginal Liaison Officer or to contact Department of Communities staff if he had felt it necessary, but he didn't think they would have been likely to be available during the festive season and he did not consider it necessary.[99]

98. Dr Teoh denied that his decision was influenced by a 'diagnostic fixation' on the issue of drug intoxication when it came to Miss T. He was aware that the blood tests showed an inflammatory response in Miss T due to the elevated white cells, and he agreed that he and Dr Hamid had discussed that issue. Although the result could be confounded by drug use, it would certainly not be the sole cause of that result, so Dr Teoh knew that the cause of the inflammatory response needed to be explored further. He felt at that time that it was possibly a very early inflammatory response at that stage and further exploration could be done over the following days. Dr Teoh gave evidence he did explain to Miss T that it was vital that she continued to have the

[96] T 149, 164; Exhibit 1, Tab 30 [40] - [41].
[97] T 155, 162; Exhibit 1, Tab 30.
[98] T 149, 164; Exhibit 1, Tab 30 [69].
[99] T 150, 165.

issue investigated, either by going to her regular doctor or coming back to the ED, so she could be monitored to see how the natural progression of the disease unfolded and where the infection was coming from.[100]

99. Dr Teoh confirmed in his evidence that it was not apparent to him that Miss T's infection was severe at that time or he would have kept her in hospital and started her on antibiotics. He had no expectation that she would become so unwell so quickly after leaving hospital. Dr Teoh expressed his regret at the unexpected outcome in this case and expressed his personal condolences to Miss T's family.[101]

EVENTS LEADING UP TO DEATH ON 25.12.2016

100. Miss T's sister, who had sent her to the hospital by ambulance that day, recalled Miss T returning home that day. Miss T's sister stated she was shocked because she didn't expect her to be let out of the hospital. She recalled Miss T looked really weak and she asked Miss T, "Why was she home?", "What was wrong with her?" and "Was she on any antibiotics?"[102]

101. Miss T told her sister that they had let her go after giving her some painkillers and telling her not to eat until they knew what was wrong with her. She didn't explain further. Miss T appeared nauseous and declined anything to eat, although she drank a lot of water. Her sister made her up a bed in the lounge room, with a fan on to keep her cool, then left to go and clean up Miss T's earlier vomit from the morning. Miss T slept with her nieces that night.[103]

102. At about 4.00 am on 25 December 2016, Miss T called out to her sister that she was feeling sick. She kept asking for a bucket and a blanket. Miss T's sister got up and got her a bucket. Miss T's sister then began tending to her children, who had woken up as well. Not long after, Miss T began vomiting. Miss T's sister left the room briefly to get something and quickly returned after her son called out to her in a frightened voice. When she ran back inside, she saw Miss T was vomiting and shaking and her eyes were rolling back in her head. Miss T's sister put Miss T on her side and tried to position her head and open her mouth to keep her airways clear of vomit. At that stage, she noted Miss T's jaw was locked shut.[104]

103. Miss T's sister ran outside and spoke to some people out the front of the house to ask for help. One of them came inside to help try to hold Miss T and keep her airways open. While he did this, Miss T's sister ran to a neighbour's unit to ring for an ambulance.[105]

104. Two separate calls were made to the '000' system. The first was made by a neighbour at the request of Miss T's family. The information able to be provided was quite limited, but it was conveyed that it was a female and she was not breathing and

[100] T 154 – 155, 162.
[101] T 160 – 161, 175]
[102] Exhibit 1, Tab 9 [50].
[103] Exhibit 1, Tab 9.
[104] Exhibit 1, Tab 9.
[105] Exhibit 1, Tab 9.

possibly having a fit. There was an attempt by the operator to pass on some first aid instructions but the focus appeared to be more on the fitting than the fact she wasn't breathing. The second call was made by another neighbour who also was asked by a family member to call for an ambulance. He was told that an ambulance was already on its way.[106]

105. Miss T's sister returned from the neighbour's house to her unit and sat with Miss T, tapping her back and trying to keep her head positioned so that the vomit would flow out of her mouth and not block her airways. Miss T's sister noted Miss T's stomach appeared bloated at this stage. She estimated they waited about 20 minutes until the ambulance officers arrived. During that time, she believed she could feel Miss T's heart beating and feel her pulse.[107]

106. When the ambulance officers arrived, Miss T's sister stepped away and allowed them to assess her sister.[108]

107. According to the Patient Care Record, SJA received a call at 4.32 am and the ambulance arrived at the scene at 4.42 am. At the time of their arrival, Miss T was lying on her side with what the ambulance officers believed to be no signs of life and signs of rigor mortis. They received conflicting accounts from family members as to the last time Miss T was seen alive. No resuscitation was attempted.[109] She was declared life extinct by a SJA paramedic at 4.45 am on Christmas Day.[110]

108. The paramedic told Miss T's sister that, sadly, Miss T had died and it was too late to try to resuscitate her. Miss T's sister was deeply distressed by the news.

109. The WA Police were notified of the death and four police officers arrived at approximately 5.00 am. The police officers assessed the unit for anything that might make the death appear suspicious. They noted Miss T did not appear to have any injuries and they did not see any drugs or medication near her body. The house was untidy, but did not show signs of a disturbance. Senior Constable Francis, spoke to Miss T's sister. Despite her obvious distress, she was able to tell Senior Constable Francis about an assault on Miss T by her father in the days prior. At about this stage, Senior Constable Francis declared a protected forensic area and police officers began scene guard duty until detectives arrived. The police treated Miss T's death as suspicious due to her age, her attendances at hospital and possible assaults in the two weeks prior to her death.[111]

CAUSE AND MANNER OF DEATH

110. A post mortem examination was performed by Forensic Pathologist Dr Gerard Cadden on 29 December 2016. The examination showed:[112]

[106] Exhibit 1, Tab 12A [20].
[107] Exhibit 1, Tab 9.
[108] Exhibit 1, Tab 9.
[109] Exhibit 1, Tab 19.
[110] Exhibit 1, Tab 3.
[111] Exhibit 1, Tab 10 and Tab 11 and Tab 12A - B.
[112] Exhibit 1, Tab 4A and Tab 5.

- Acute small intestine obstruction involving virtually the entire length of the small intestine with an area of obstruction immediately proximal (300mm proximal) to the ileocaecal junction. This area of obstruction would appear to be on account of adhesions in association with left peri-ovarian abscess in the presence of acute purulent endometrial infection;
- Pulmonary congestion with small pleural effusions and a small degree of ascites (often seen in the setting of acute cardiac failure);
- No evidence of any significant trauma; and
- No other systemic preceding pathology.

111. Microbiology results were positive for gonorrhoea (*Neisseria gonorrhoeaea*) from the blood, uterus, vagina, left ovary, peri-ovarian region and left fallopian tube samples. This raised the possibility that Miss T was septic at the time of her death.[113]

112. Neuropathology found no significant abnormalities on macroscopic examination of the brain.[114]

113. Toxicology showed paracetamol and codeine at therapeutic levels, consistent with Miss T being given Panadeine Forte in hospital. Tetrahydrocannabinol was found in the ante-mortem hospital blood samples taken on 24 December 2016 but the test for amphetamines was negative on the hospital antemortem blood.[115]

114. The Chemistry Centre results of the hospital antemortem blood also identified acetone, giving an approximate amount. The whole blood glycated haemoglobin was reported at a level which, if seen in a living person, would be indicative of poor glycaemic control. These findings, taken along with the history, raised in Dr Cadden's mind the possibility that Miss T may have had latent diabetes mellitus. If this were the case, it would account for the anion gap metabolic acidosis.[116]

115. At the conclusion of all investigations, Dr Cadden expressed the opinion the cause of death was acute abdominal obstruction secondary to adhesions associated with severe pelvic inflammatory disease. Dr Cadden noted that the degree of small bowel obstruction was severe, as was the pelvic inflammatory disease. The microbiology results indicate the inflammation was due to the presence of the sexually transmitted disease gonorrhoea.[117]

116. I note in the interim report to the Coroner, Dr Cadden indicated he was aware of the history of assault to the head region some weeks before Miss T's death, and the fact that due to that history the death had been treated as suspicious. However, based on his post mortem examination findings, Dr Cadden noted that he considered there was a natural cause in respect to the cause of death, which is the cause of death recorded above. Dr Cadden found no evidence of any injury being connected to the death.[118]

[113] Exhibit 1, Tab 4A and Tab 5 and Tab 8.
[114] Exhibit 1, Tab 4A and Tab 7.
[115] Exhibit 1, Tab 4A and Tab 6.
[116] Exhibit 1, Tab 5 and Tab 6.
[117] Exhibit 1, Tab 4A.
[118] Exhibit 1, Tab 4B

117. Dr Cadden also expanded upon Miss T's history, and his opinion in relation to the cause and manner of death, in correspondence with Dr Thomas Hitchcock, who as noted below was preparing an expert opinion for the court at the time. Dr Cadden confirmed his understanding that Miss T had been exposed to violence in two incidents prior to her death, once involving a fight with another girl and another, potentially more serious, physical altercation with her father, where she was possibly even rendered unconscious. He was aware she had been to hospital shortly prior to her death after complaining of pain and vomiting. After being sent back into the community from hospital, she was noted to be in pain and vomiting again at home before collapsing and by the time an ambulance was called she appears to have been beyond help.[119]

118. Dr Cadden had not been supplied with the SJA Patient Care Record so he could not comment on the suggestion that rigor mortis was already pronounced when the ambulance officers arrived. However, Dr Cadden did suggest that he would be very circumspect when commenting on someone else's observations regarding rigor mortis. Dr Cadden noted that the generally accepted approach is that rigor mortis would be expected to be seen 2 – 4 hours after death, however, this can vary greatly. Dr Cadden noted that the suggestion that rigor mortis was present would cast considerable doubt on the account given by Miss T's sister.[120]

119. Dr Hitchcock commented that in his correspondence with Dr Cadden and review of the post mortem findings, it is apparent that there are multiple pathological mechanisms resulting in Miss T's death rather than a single simple pathway. He noted there is evidence of uncompensated shock and subsequent cardiac failure. Uncompensated shock is a clinical state where the circulation fails to meet the metabolic requirements of the tissues and, without urgent resuscitative management and treatment of any reversible cause, results in failure of a vital organ resulting in death.

120. There is evidence that hyopvolaemic shock (depleted volume of blood circulating which can be due to dehydration) and sepsis were present at the time of death and Dr Hitchcock believes it is likely that both of these clinical states contributed to uncompensated shock. Dr Hitchcock noted the bowel obstruction detected will cause fluid to move out of the circulation, plus patients vomit and do not replenish fluids due to feeling sick, which results in dehydration and hypovolaemia. Further, there was evidence of a blood infection (septicaemia). The cause of the bowel obstruction and septicaemia was severe pelvic inflammatory disease caused by gonorrhoea.[121]

121. Dr Hitchcock also noted there was evidence of early or latent insulin dependent diabetes, as referred to above by Dr Cadden, and this can result in dehydration that may have contributed to the final episode of uncompensated shock. Miss T was also severely underweight with ketosis, with a BMI that put her in the 0.1 percentile for her age and would be regarded as severely underweight, which causes its own problems.[122]

[119] Exhibit 1, Tab 5.
[120] Exhibit 1, Tab 5.
[121] Exhibit 1, Tab 21.
[122] Exhibit 1, Tab 10.

122. Dr Hitchcock expressed the opinion, after discussing the case in death with Dr Cadden, that the mechanism of death of Miss T was due to shock as a result of septicaemia.[123]

123. A detective from Kalgoorlie Detective's Office, who was investigating whether any criminal charges might arise from Miss T's death, noted Dr Cadden's post mortem findings and indicated there was no other evidence to suggest that Miss T's death arose from anything other than natural causes.[124] This was confirmed by Sergeant Forbes in his evidence at the inquest.[125]

124. I accept and adopt the opinion of Dr Cadden as to the cause of death, noting the cause of the severe pelvic inflammatory disease was gonorrhoea. I find that the death arose by way of natural causes.

REVIEWS OF THE MEDICAL CARE

SAC1 – WACHS Clinical Incident Investigation

125. Miss T's death prompted an internal investigation at the hospital as her death was categorised as a clinical incident. The investigation found the documentation by the nursing staff and RMO was good and the initial treatment was sound. It also found the escalation of the findings and concerns from nursing staff to the RMO, and from the RMO to the Emergency Consultant was appropriate, and done in a timely manner.[126]

126. Ultimately, the investigation found that there may have been a diagnostic fixation on the part of the Consultant that drug intoxication focus was the cause of the symptoms, which reduced further consideration of a possible occult sepsis, requiring further observations and possible admission to hospital. The Consultant indicated that he had considered an infective source to her presentation, but it had not been apparent at the time. It was noted that the Consultant had indicated that if a Short Stay area had been available in the ED, he would have more than likely admitted Miss T to that area for observation. It was concluded that the case demonstrated the need for improvement in the hospital in the area of sepsis in high risk patients, including people of Aboriginal descent.[127]

Dr Hitchcock's Report

127. Dr Thomas Hitchcock is a Consultant in Emergency Medicine and Emeritus Consultant for Patient Safety with the Department of Health, amongst other things, and has many qualifications in the field of clinical forensic medicine. Dr Hitchcock was asked by the Court to provide an expert opinion on the care provided to Miss T

[123] T 109.
[124] Exhibit 1, Tab 10.
[125] T 14 - 15.
[126] Exhibit 1, Tab 22.
[127] Exhibit 1, Tab 22.

at Kalgoorlie Hospital on 24 December 2016 and whether he considered more should have been done to investigate her condition prior to her discharge. Dr Hitchcock was given information in relation to the earlier hospital presentation, as well as information relating to the circumstances of Miss T's death, to provide context to his report.

128. Dr Hitchcock commented that Miss T's death from overwhelming septic shock from gonorrhoea is rare, and small bowel obstruction complicating severe pelvic inflammatory disease is unusual. For these to occur simultaneously in an individual with latent diabetes, ketosis and low BMI is unique.[128] Therefore, the starting point of Dr Hitchcock's analysis was that Miss T's case was very complex and, in his experience, unique.[129]

129. Dr Hitchcock noted that at the time of Miss T's presentation on 24 December 2016 there was information available to identify that she:[130]

- had abdominal pain due to an unknown cause,
- had wide anion gap metabolic acidosis with ketosis due to an unknown cause,
- had dehydration, hypotension and tachycardia responsive to IV fluid therapy,
- showed recent drug use,
- was underweight with a BMI below 15,
- had a high white cell count with neutrophilia,
- had raised inflammatory markers, and
- a concerning presentation of alleged assault 14 days earlier.

130. The evidence does, however, indicate that Miss T was not in septicaemic shock at the time she presented. In Dr Hitchcock's view, there was not enough in the information above to clearly predict the complex and unique set of circumstances that led to Miss T's death. In particular, there was no evidence on clinical or biomechanical assessment of either compensated shock, decompensated shock or heart failure, so the onset of these conditions must have occurred after she was discharged.[131]

131. Dr Hitchcock also gave evidence that, while there were some features associated with sepsis in Miss T's presentation, there was no clear entry point to indicate the doctors should have followed the adult sepsis pathway. Dr Hitchcock also found nothing readily identifiable to suggest the treating doctors should have made more enquiries about her sexual history at that stage.[132]

132. However, Dr Hitchcock also expresses the opinion that there was enough information available on 24 December 2016 to identify that Miss T required further therapy and investigation.[133]

133. In his opinion, a reasonable plan would have been to implement:[134]

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[128] Exhibit 1, Tab 21.
[129] T 109, 137; Exhibit 1, Tab 21.
[130] Exhibit 1, Tab 21.
[131] T 110; Exhibit 1, Tab 21.
[132] T 113 – 114, 120.
[133] T 111; Exhibit 1, Tab 21.
[134] T 111; Exhibit 1, Tab 21.

- IV rehydration with normal saline and dextrose, aiming to maintain cardiovascular stability and treat ketosis if due to low calorie intake,
- Fluid balance chart to monitor her response to IV fluid therapy,
- Hourly observations to guide the IV therapy and detect any further instability,
- Repeat full blood test and other testing and review in 4 – 6 hours to determine progression of possible sepsis and either resolution or persistence of ketoacidosis,
- Blood cultures if she was febrile and consideration of IV antibiotics if ongoing signs of sepsis developed as the clinical picture on presentation may have been due to an infection,
- Repeat examination and surgical opinion of undiagnosed abdominal pain.

134. In Dr Hitchock's opinion, this type of management plan may have resulted in a more timely diagnosis and early identification and treatment of the decompensated shock and heart failure that were features of Miss T's death.[135] This type of care required admission to an inpatient unit, observation ward or short stay unit. Inpatient management would also have provided an opportunity to define and develop a plan for her low BMI, dependent on cause, and review her social circumstances, drug use and recent domestic violence, noting she was only 16 years old and it was important to ensure that she had a safe place to go home to after discharge.[136]

135. Dr Hitchcock expressed the opinion that if Miss T had been admitted to hospital at the time of her presentation on 24 December 2016, it is possible her death could have been prevented. In providing that opinion, Dr Hitchcock acknowledged that he has not worked at the Kalgoorlie Health Campus and, in comparison to that hospital, Dr Hitchcock works in a "very privileged setting,"[137] that includes options of a short stay or observation ward under the governance of emergency medicine, a short stay acute medical unit and a short stay acute surgical unit. These are options that were not available to Dr Teoh at Kalgoorlie Hospital. Dr Hitchcock agreed that, without a diagnosis and without these kinds of other options, it was more difficult to have Miss T admitted for observation, but he considered it was still the appropriate course to have taken as it was apparent she was sick, even if no diagnosis could be formulated at that time.[138]

136. Dr Hitchcock was also asked to consider whether there was too much focus on Miss T's drug use, noting the findings of the hospital's SAC1 investigation. Dr Hitchcock noted that cannabis hyperemesis syndrome is typically seen in chronic marijuana use and causes recurrent abdominal pain, vomiting and nausea and it was possible that this diagnosis was considered by the doctors involved given her admitted cannabis use and her symptoms. However, it was unclear from the discharge summary whether the doctors believed the marijuana use was the cause of her abdominal pain and Dr Hitchcock noted that Miss T was given sensible advice on discharge not to smoke marijuana, given its association with abdominal pain, in any event. Ultimately, in Dr Hitchcock's opinion, he did not think there was any evidence in the

[135] Exhibit 1, Tab 21.
[136] T 111; Exhibit 1, Tab 21.
[137] T 112.
[138] T 112; Exhibit 1, Tab 21.

notes of an over-emphasis on drug use issues, which is consistent with Dr Teoh's evidence.[139]

137. Putting her admitted drug use to one side, Dr Hitchcock expressed the opinion that there were other features present that did not appear to be recognised, or given appropriate significance, in Miss T's case. This included the fact she was severely underweight and her blood gas analysis identified signs she might have undiagnosed diabetes. Despite the fact she was 16 years old and having repeated presentations to hospital, no thought was given to exploring her social circumstances to find out if there was a responsible adult to care for her and she appears to have been discharged alone. Further, her discharge plan involved referral to her GP for follow-up, even though it was unclear whether she had a regular GP and no such GP was identified in the medical records, and she was being discharged at the start of the Christmas public holidays, which made it very unlikely she would be able to see a GP in the next couple of days.[140]

138. Dr Teoh, in his evidence, indicated that Miss T told him she was a patient of the Bega Garnbirringu Health Service and she was happy to reattend that GP practice. Dr Teoh was aware that the Bega medical centre would be closed on the public holidays, but otherwise it would be open during the festive period. Therefore, he considered that attendance at her GP formed part of the 'safety net' of her discharge. He also understood that she would be going home to a place where a responsible family member would care for her. This satisfies some of the concerns raised by Dr Hitchcock, but not all of them.[141]

139. Dr Hitchcock still considered there were issues concerning Miss T's social circumstances and low body weight, as well as some quite abnormal physiology without a diagnosis available, that warranted a further period of observation. This was in spite of the fact that Miss T had shown some improvement following treatment.[142]

140. If Miss T had been kept in for further observation, knowing she died of septic shock, the opportunity to enter the sepsis pathway and begin to treat her appropriately would then most likely have arisen. However, because she was discharged, that opportunity was missed. It was clear that Miss T's sepsis happened very, very quickly, so there was no chance for her family to realise and return her to the hospital for further help.[143]

Dr Tembo's Report

141. Dr Jonathon Tembo is the Acting Head of the Emergency Department at Kalgoorlie Regional Hospital and he provided a report he prepared shortly prior to this inquest, as well as giving evidence at the inquest. The report addressed the opinion of

[139] T 118; Exhibit 1, Tab 21.
[140] Exhibit 1, Tab 21.
[141] T 146 - 147.
[142] T 125, 128.
[143] T 135, 138 -139.

Dr Hitchcock in relation to the care provided to Miss T at the hospital prior to her death, as well as provided comment and current information on the SAC1 and the changes that have been implemented since that investigation was completed.[144]

142. At the start of his evidence, Dr Tembo offered his heartfelt condolences to Miss T's family, as well as condolences on behalf of Kalgoorlie Hospital, and he expressed his hope that the inquest process would answer some of the questions the family might have and that the process might give them some closure. Dr Tembo also wished to emphasise how greatly adverse outcomes like this affect the clinicians involved, and also from that perspective all of those involved wish to "strive to make the system better."[145] Dr Tembo attempted to answer all questions put to him by counsel with these purposes in mind.

143. Dr Tembo indicated in his report that he generally agreed with the opinion of Dr Hitchcock, other than in relation to certain specified items, including whether Miss T may have had diabetic keto-acidosis, as the features that suggested that diagnosis were also consistent with her history of vomiting. Dr Hitchcock agreed in his evidence that there was uncertainty in this case as to whether she was simply in starvation ketosis or whether there was also an underlying latent insulin-dependent problem, which was another indicator as to why she needed to be observed and the tests repeated.[146]

144. Dr Tembo agreed that a rapid deterioration in Ms T's condition could not have been predicted, not only for the reasons identified by Dr Hitchcock, but also because Miss T was a rapid responder to supportive treatment in the ED and her documented vital signs were normal at the time of her discharge from the ED. He suggested that Miss T was able to compensate and fight the infection for a considerable period, and it may not have been apparent until the last few minutes, or last hour or two, that she was succumbing. It was too late for anything to be done when this occurred, given she had left the hospital, but her deterioration may have been picked up if she had remained under medical observation, prompting administration of antibiotics and other first line treatment for sepsis.[147] Dr Tembo could not be certain this would have changed the outcome, but it would "have given her the best shot."[148]

145. Nevertheless, Dr Tembo also agreed with Dr Hitchcock that there was sufficient information available on 24 December 2016 to indicate that further therapy and investigation was required prior to Miss T being discharged home. He concurred that the medical record 'had features suggestive of an infective process, likely Occult abdominal Sepsis."[149] In particular, Miss T had abdominal pain, vomiting and was dehydrated and the results of her blood tests were suggestive of sepsis, although she did not have all the features of infection.[150]

[144] Exhibit 1, Tab 31.
[145] T 177.
[146] T 115; Exhibit 1, Tab 31.
[147] T 193; Exhibit 1, Tab 31.
[148] T 194.
[149] Exhibit 1, Tab 31 [10].
[150] Exhibit 1, Tab 31.

146. Dr Tembo gave evidence that it would have been possible to have admitted Miss T without a final diagnosis. It would be for the emergency physician to make the critical decision that they did not think it was safe for the patient to go home. In that sense, Dr Tembo gave evidence that the decision-making was not limited at the time due to the absence of a short-stay unit at Kalgoorlie Hospital. However, he also agreed with Dr Teoh that the need to work in a much more collegial way in the country hospital setting might make it difficult to make that decision unilaterally, and would likely require some discussion with the registrar or consultant of the admitting unit.[151]

147. Dr Tembo also agreed with Dr Hitchcock's opinion as to what would have constituted a reasonable initial treatment plan in those circumstances.[152]

148. Dr Tembo noted in his evidence that Miss T was kept in the hospital ED for some time in any event,[153] although I note it does appear she was discharged close to the expiry of the 'four hour' time frame.

149. Dr Tembo provided information about changes that have been made at Kalgoorlie Hospital since Miss T's death and the hospital's SAC1 investigation into her death, with the hope that her family could be reassured that her death was not in vain.[154] An Action Plan was developed, which included work on the WACHS Sepsis Identification and Management Strategy. Kalgoorlie Hospital, as well as a number of other regional hospitals and medical centres, participated in a pilot of the WACHS Adult Sepsis pathway and quick sepsis-related organ failure assessment, as part of that strategy, which was intended to capture patients with possible sepsis for timely and appropriate management. Those documents are now incorporated into the clinical practice in Kalgoorlie Hospital's ED, and across WACHS, and are supplemented by targeted educational activities, incorporating aspects of Miss T's presentation.[155]

150. Dr Tembo also advised that the hospital's approach to family and domestic violence is now much more robust, with family and domestic violence issues flagged at triage with a specific alert to prompt further action by doctors and nurses, such as a referral to the hospital's social worker, and tools are provided to help guide discussion and enable hospital staff to provide a supportive response in such circumstances.[156]

COMMENTS ON PUBLIC HEALTH

Support for a Short Stay Unit

151. Dr Hitchcock provided some information about the WEAT or 'four hour rule'. In Dr Hitchcock's opinion, there are some good things about the rule, as it allows for

[151] T 183 - 185.
[152] Exhibit 1, Tab 31.
[153] T 186.
[154] T 192.
[155] T 192; Exhibit 1, Tab 31, Attachments 6 - 8.
[156] T 192; Exhibit 1, Tab 31, [13] – [16], Attachments 1 – 2.

information to be collected and reported, which enables transparency about how hospitals perform, not just in the Emergency Department but throughout the hospital, as it reflects access block to inpatient beds, as well as what is occurring in terms of overcrowding in the ED. However, Dr Hitchcock acknowledged the difficult thing about the rule is that, as a clinician working in the ED, there is an expectation that the doctor is going to come up with a diagnosis in a short timeframe, which in a case with a high level of complexity is unrealistic.[157]

152. Dr Tembo also emphasised that WEAT is a "hospital-wide target,"[158] as it reflects bed availability on the wards as well as how quickly people are seen, and then moved through, the ED. Further, Dr Tembo indicated that as a clinician, he would have WEAT in his mind but he would not compromise a patient's care at any stage in order to achieve it.[159] Nevertheless, the evidence was clear that there is always that understanding from the ED doctors' perspective that they need to be managing patients quickly, with that overall target in mind.

153. Dr Teoh explained that, from his perspective, the WEAT puts additional pressure on ED doctors to make decisions quickly and sometimes that will lead them to "revert to the pattern recognition decision making capacity at times in the midst of pressure, in the midst of reaching a target."[160] Dr Teoh gave evidence that this did not apply all the time, but when the department became busy, and he was the sole person responsible for the ultimate decision making, "the cognitive load is very heavy"[161] and this might occur. Dr Teoh noted that he was also making these decisions in a situation where beds are "premium real estate."[162]

154. In that context, Dr Teoh gave evidence that the availability of an option to admit someone who is diagnostically very unclear, such as a short stay unit, would be helpful at Kalgoorlie Hospital, because it would provide a safety net for patients who are diagnostically unclear, in order to monitor the patient for a bit longer and see how the disease process unfolds. However, Dr Teoh also indicated that many patients will prefer to go home and be monitored by family members at home in such cases.[163]

155. As noted above, Dr Hitchcock works in a hospital that has a short stay unit available under the governance of the emergency department, as well as a short stay acute medical unit under the governance of inpatient physicians and short stay acute surgical unit under the surgical team. Dr Hitchcock expressed the opinion that the ability to keep a patient in for observation is important, as well as the ability and confidence to admit a patient even without a clear diagnosis, if they are genuinely concerned about the health and welfare of a patient. Dr Hitchcock also noted that the short stay units are a valuable tool in domestic violence cases, where there can be an

[157] T 116 – 117, 132.
[158] T 191.
[159] T 191.
[160] T 149.
[161] T 149.
[162] T 150.
[163] T 155.

opportunity to look into the patient's social circumstances and develop a good safety plan, which he considered was a relevant feature in Miss T's case.[164]

156. Dr Hitchcock expressed the opinion that "the observation ward issue is intrinsically linked with Emergency Department admission rights into hospitals,"[165] so that they can either admit without a diagnosis or have that opportunity to monitor for a longer period than the four hour rule allows. Dr Hitchcock gave evidence that there is clearly a rate of error in emergency departments (that has been put at up to 30%) which can in part be attributed to doctors being forced to make a diagnosis where none is available, although in other cases it's just because they are wrong. Dr Hitchcock noted that some mistakes are inevitable, particularly in the busy and pressured environment that is a hospital emergency department, and looking back it is helpful to consider that there are both individual and system errors that lead to poor outcomes.[166]

157. While Dr Tembo emphasised that it was the case then, and is now, that a patient will be admitted at Kalgoorlie Hospital if the ED physician makes the critical decision that is not safe for them to go home, he also agreed that the addition of a short stay unit would greatly help in the way they could manage patients like Miss T and make decisions regarding admission more easily. Further, Dr Tembo agreed that there is an ongoing need for a short stay unit at Kalgoorlie Hospital for patients like Miss T, where the clinical decision to admit or discharge is closely balanced, as well as patients who are drug affected (which Miss T possibly was), who have family and domestic violence issues (like Miss T was experiencing) and it might not be safe for them to go home or there is a need to sort out their situation and ensure that they are not homeless or in need of support from other agencies.[167]

158. The WACHS has advised that six WACHS hospitals currently operate a Short Stay Unit or an ED Observation Unit: Bunbury, Busselton, Albany, Geraldton, Hedland and Karratha. The latter two have only recently been established, and there are plans to commence a similar unit at Broome Hospital later this year. No funding has currently been made for a Short Stay Unit or ED Observation Unit at Kalgoorlie Health Campus, although WACHS and WACHS Goldfields are supportive of the proposal.[168]

159. Information provided by WACHS indicates that in the currently operating short stay and ED observation units operating at regional hospitals, almost all of the patients in the currently operating units were admitted from the relevant emergency department and the usual length of stay of a patient is a little bit less than 11 hours. This shows that the desired intention of a short stay unit is being met. Further, 81% of the patients are discharged from the units, and the re-attendance rates for those patients is significantly lower than for patients who are discharged home directly from the ED.[169]

[164] T 117, 121.
[165] T 124.
[166] T 136.
[167] T 183; Exhibit 1, Tab 31, [45].
[168] Submissions and Further Informed on behalf of the WACHS filed 19 November 2021, [18] – [22].
[169] Submissions and Further Informed on behalf of the WACHS filed 19 November 2021, [19] – [20].

160. I am satisfied that there is an obvious role for a Short Stay Unit at Kalgoorlie Health Campus to improve the ability of the ED doctors to manage patients like Miss T, who require observation for a longer period but where there is no obvious diagnosis. I am satisfied that if such a unit had been available at the time of Miss T's presentation to the ED on the night before her death, Dr Teoh would have used it and Miss T's death may well have been prevented.

Recommendation 1

I recommend that the Honourable Roger Cook MLA, Deputy Premier and Minister for Health, give consideration to funding the creation of a short stay unit at Kalgoorlie Health Campus, which would operate under the governance of the Emergency Department in a similar way to those already established at other large regional health campuses in Western Australia.

Aboriginal Sexual Health and Blood-borne Virus Strategy

161. Research has been established that, for a multitude of reasons, Aboriginal and Torres Strait Islander people experience a greater burden of disease related to blood borne viruses and sexually transmitted infections. As a result, the Australian Government has developed the Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018 – 2022. The strategy recognises and acknowledges the unique needs of Aboriginal and Torres Strait Islander people and communities and proposes dedicated and tailored approaches to respond to these issues.[170] It replaced previous strategies with the same focus.

162. As well as the national strategy, Western Australia's Department of Health has its own Western Australian Aboriginal Sexual Health and Blood-borne Virus Strategy 2019 – 2023, which is closely aligned with the national strategy.[171] Of relevance in this case, the WA strategy includes a target to "reduce the incidence and prevalence of gonorrhoea and chlamydia with a focus on young people."[172]

163. In Australia, people aged 15 to 29 years experience higher rates of diagnosed STI's compared to other age groups, and while the rates are also high in young non-Indigenous people, rates are substantially higher in young Aboriginal and Torres Strait Islander people. Recent studies have suggested that the difference is less to do with differences in risk-taking and health-seeking behaviours, and more to do with a lack of accessibility of services. Barriers faced by young Aboriginal and Torres Strait Islander people in accessing health services include "stigma, shame, confidentiality concerns and the absence of age-responsive or culturally responsive services."[173]

[170] Exhibit 1, Tab 25A.
[171] Exhibit 1, Tab 25B
[172] Exhibit 1, Tab 25B, p. 5, Target 7.
[173] Exhibit 1, Tab 25A, p. 26.

164. As I noted above, I was advised at the conclusion of the inquest that in the past 12 to 24 months some significant improvements have been made to the Bega Health Service, including the employment of a dedicated sexual health nurse and an ability to now perform onsite testing via the Point of Care units enabling the service to test for the sexually transmitted infections Syphilis, Trichomonas, Chlamydia and Gonorrhoea.[174] Bega Health has also worked on establishing a close working relationship with the WACHS Goldfields Public Health Unit to coordinate treatment and contact tracing of clients identified with a sexually transmitted infection. These important changes show that Bega Health has recognised the need to be proactive in the investigation and treatment of sexually transmitted infections, which are statistically more prevalent in the clients who attend this service.

165. The contact tracing is important given what is known about the mobile nature of the lifestyles of many of the clients, Miss T being no exception. Many Aboriginal people may not regularly attend either the same GP, or any GP regularly, so there needs to be a low threshold to investigate and treat suspected STI's before that opportunity is lost, and active follow up is an important part of that process. Early detection and treatment is crucial to preventing long term complications, of which Miss T is a tragic example.

166. In submissions filed on behalf of Miss T's family, it was also suggested that health practitioners who work in Kalgoorlie would benefit from further cultural awareness training, specifically including face-to-face training, and also a focus on employment and engagement of Aboriginal staff at Kalgoorlie Health Campus. Although there are Aboriginal Liaison Officers employed there, they are only employed during normal business hours, which is not as useful in a 24 hour Emergency Department. It is possible that, if an ALO had been available, and noting the difficulties the doctors faced in obtaining a clear history from Miss T, they might have sought the assistance of an ALO to speak to Miss T. In his evidence, Dr Tembo was very complimentary of the role that ALO's play in the Kalgoorlie Hospital ED, and he agreed that having one available when Miss T was being reviewed would have helped in this situation. Although we can't be certain she would have disclosed the highly relevant gynaecological information she had already disclosed at Bega Health, there is a greater likelihood she would have been more comfortable speaking with a culturally appropriate person, particularly if it was a woman.[175]

167. Counsel for WACHS has provided helpful information on the cultural awareness training that is provided to WACHS Goldfield employees,[176] which is an important tool to assist all staff to be aware of historic issues, social issues and cultural protocols when dealing with Aboriginal patients, but this kind of training cannot substitute for the role played by Aboriginal Liaison Officers.

[174] Exhibit 2C.
[175] T 189.
[176] Submissions and Further Informed on behalf of the WACHS filed 19 November 2021.

Recommendation 2

I recommend that the Honourable Roger Cook MLA, Deputy Premier and Minister for Health, give consideration to funding the employment of Aboriginal Liaison Officers in the Kalgoorlie Health Campus Emergency Department to provide a 7 days per week/24 hours per day culturally appropriate liaison service to facilitate better communication between Aboriginal patients and health staff.

COMMENTS ON COMMUNITIES' CARE

168. Mr Glenn Mace is the Executive Director at Statewide Services at Communities. Mr Mace provided a detailed report of Communities' contact with Miss T and her family, which provided the information set out above as background, and Mr Mace also spoke to his report at the inquest. Mr Mace acknowledged that there was some duplication of referrals in Miss T's case, due to her transience, which is now managed differently by Communities.[177]

169. The Communities' Incident Report for the alleged assault on Miss T by her father noted that Miss T was "a transient young person with a history of past unsubstantiated neglect."[178] The intention of the investigation at that time was to find Miss T and make sure she was okay and had somewhere safe to live with a responsible adult. It was noted that at 16 years of age she had shown relative independence and had exhibited experience making her own choices with respect to where to stay and whom to stay with, but it was important to ensure that if she chose to live with her father, there was a safety plan to make sure she was not physically harmed again.[179]

170. Mr Mace indicated that he had reviewed the case and had not found anything to suggest something should have occurred in Communities' handling of this case that didn't occur. However, he did indicate that since Miss T's death, the Department has moved to a stronger focus on a 'series of incident's or the cumulative effect of incidents, rather than dealing with each event in isolation, which helps to build up a picture. This might have altered the pattern of engagement with Miss T's family.[180]

171. Mr Mace also pointed to the suite of new services commissioned from Aboriginal-controlled organisations, both in the metro and regional areas, whose role it is to engage and work with Aboriginal families and provide practical assistance, which may also have assisted.[181]

172. He noted that it can be challenging when dealing with 'street-wise' young people to determine how hard to pursue contact, as there is the risk they will go into hiding.

[177] T 197.
[178] Exhibit 1, Tab 26B.
[179] Exhibit 1, Tab 26B and Tab 26C.
[180] T 201 - 202
[181] T 205.

Communities had tried unsuccessfully to locate Miss T after the alleged assault but it would seem Miss T was reluctant to engage with them. Communities' staff were still trying to make contact with her at the time of her death.[182]

173. I note that the Kalgoorlie Hospital staff did not attempt to contact Communities' staff before her discharge on 24 December 2016.

174. Submissions were made on behalf of Miss T's family that the Kalgoorlie Hospital staff should have ensured that Miss T left the hospital accompanied by a responsible adult, or alternatively should have sought assistance from Communities, even allowing for the timing of events.[183] I note that Mr Mace confirmed there is a Crisis Care on call service, at all times, but he was uncertain what steps they might have taken if called in this case.[184] Dr Tembo confirmed it was his expectation that, as much as possible, where patients who have not reached the age of maturity are discharged, they would like to involve a relative or substitute decision-maker like Communities in their stead. Given her first presentation involved direct allegation of family and domestic violence, which also flowed into the next presentation, under new processes implemented since Miss T's death, mandatory family and domestic violence forms would also need to be completed with follow up plans.[185]

175. Dr Teoh indicated he was satisfied that Miss T was going home to supportive family that was not her father. He appears to have treated Miss T as a mature minor who was capable of understanding the clinical information he provided to her and making independent decisions. However, it is clear from the evidence of her sister that when she returned home, she did not give a clear account of the circumstances of her discharge to her sister. In hindsight, it would have been preferable for the hospital staff to have made more enquiries about the circumstances of Miss T's family support, and attempted to have a responsible adult come in to collect her, so that they also had an understanding of her circumstances and 'red flags' to watch out for. Then, when Miss T began mentioning feeling unwell again in the morning, her sister might have been in a better position to take action. It's likely that it may have been too late by that time, given how quickly she died afterwards, but it would at least have put her family in a much better position to monitor her.

CONCLUSION

176. Miss T was a young Aboriginal girl who had suffered a violent assault and sought help twice at Kalgoorlie Hospital Emergency Department in the weeks before her death for abdominal pain. On the second occasion, despite exhibiting signs of a possible infection, she was discharged home on her own, with a plan for follow up in the community in the following days. Sadly, her condition rapidly deteriorated after she left the hospital and Miss T succumbed to an acute bowel obstruction arising

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[182] T 201; Exhibit 1, Tab 26, p. 12.
[183] Submissions filed by ALS on behalf of CD (Miss T's mother) and TR (Miss T's sister), dated 28 June 2021.
[184] T 204.
[185] T 182; Exhibit 1, Tab 31.

from complications of the infection and sepsis in the early hours of the morning, and died at home on Christmas Day.

177. The evidence indicated that Miss T's case was very unusual, as she did not exhibit the common symptoms of sepsis when examined at the hospital some hours before her death. Her presenting complaints of nausea, abdominal pain and vomiting are common presenting complaints to an Emergency Department, and in the context of her history of an assault and appearing very dehydrated, there was nothing obvious during the initial assessment to point to infection, and particularly not a sexually transmitted infection as the source of her symptoms. However, a blood test was abnormal and suggestive of infection, and there was expert evidence that in the context of all the other known circumstances, these results warranted some further therapy and observation, including repeating the blood tests to see whether something more serious was developing.

178. Expert evidence also supported the conclusion that Miss T would have stood the best chance of survival if she had remained in the hospital, as ongoing monitoring would hopefully have detected if Miss T developed a fever or became cardiovascularly unstable, and provided an opportunity to provide treatment and support. None of this was available at her home.

179. The evidence indicated that Dr Hamid and Dr Teoh were conscious of the WEAT 'four hour' rule in treating patients in the ED, and I am satisfied that it played a role in Dr Teoh's decision to discharge Miss T prematurely on the night. In circumstances where Miss T did not have a clear diagnosis, making admission to a ward difficult, there was no option to admit her for observation in a short stay observation unit, and she did not appear critically unwell, the pressure to make a quick clinical decision and discharge her for follow up in the community won out. It was very clear that, in hindsight, Dr Teoh genuinely regrets this judgment call and he has learned much from this experience.[186]

180. There was also a missed opportunity for Miss T to get treatment when she presented to a GP in between her two hospital attendances and exhibited possible symptoms of sexually transmitted infection. Again, time pressures were a factor. Her gynaecological issues were overlooked in favour of the more urgent need to ensure that she had not suffered life-threatening complications from the assault, in the context of a busy GP practice. Although there was a plan to investigate these issues the next day, Miss T did not reattend as requested and there was no follow-up.

181. The tragedy in this case was that Miss T's death was entirely preventable if her sexually transmitted infection had been diagnosed and treated at an earlier stage. The Australian government, and the Western Australian government, have identified that young Aboriginal people like Miss T are statistically more likely to suffer from untreated sexually transmitted infections, which can have serious long term health implications and even result in death, as tragically occurred in this case. Strategies have been introduced to try and address this serious health issue and prioritise unique and tailored health approaches that will work towards achieving health equality for

[186] Submissions filed on behalf of Dr Teoh, dated 26 July 2021.

all Australians. The focus is on education and prevention, as well as removing barriers to young Aboriginal and Torres Strait Islanders seeking health treatment.

182. This is a very sad case, which highlights the importance of suspecting, diagnosing and treating STI's in the young Aboriginal population in Western Australia. It is also a cautionary tale about the difficulties in diagnosing sepsis in atypical cases, and the need to have a high level of suspicion where a young Aboriginal girl presents to hospital with abdominal pain where no other cause is found. I say this in the context that, tragically, Miss T's death is not the only recent death of a young Aboriginal woman from undiagnosed sepsis in this State. We must, as a community, and more specifically as health providers, be alert to the complexities of the health situation for many young Aboriginal people in Western Australia, and the need to take a cautious approach where the diagnosis is unclear. While rules, such as the WEAT rule, have their place in monitoring the state of the health system, it must not be allowed to override the need to monitor patients until a clear clinical picture is obtained. A short stay observation unit at Kalgoorlie Health Campus might go some way to achieving this.

S H Linton
Deputy State Coroner
29 November 2021