**JURISDICTION** : CORONER'S COURT OF WESTERN AUSTRALIA

**ACT** : CORONERS ACT 1996

**CORONER** : Rosalinda Vincenza Clorinda Fogliani, State Coroner

**HEARD** : 5 - 7 JULY 2022

**DELIVERED** : 29 JUNE 2023

**FILE NO/S** : CORC 1 of 2017

**DECEASED** : Child R

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*Catchwords:*

Nil

*Legislation:*

Nil

**Counsel Appearing:**

Mr W Stops assisted the Coroner.
Ms E Langoulant and Ms R Belton (Aboriginal Legal Service) appeared on behalf of the family of the deceased.
Ms L Bultitude-Paull and Mr J Berson (State Solicitors Office) appeared on behalf of the WACHS and Dr Kuria Nemba.
Mr E Panetta and Ms C Catto (Panetta McGrath Lawyers) appeared on behalf of Dr Jennifer Allen.
Ms H Cormann on instruction from Ms S Rumenos (Clayton Utz) appeared on behalf of the Royal Flying Doctor Service.
Mr S Denman (Scott Denman Lawyers) appeared on behalf of Dr Rajkumar Ramasamy.

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

Nil

*Coroners Act 1996*
(Section 26(1))

# RECORD OF INVESTIGATION INTO DEATH

*I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of **Child R** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 5 July 2022 - 7 July 2022, find that the identity of the deceased person was **Child R** and that death occurred on 5 January 2017 at Halls Creek Hospital, 70 Roberta Avenue, Halls Creek, from complications of E. coli sepsis in association with intestinal obstruction due to faecal impaction of megacolon in a child with anorectal anomalies (operated), in the following circumstances:*

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## SUPPRESSION ORDER

**Suppression of the deceased child's name from publication and any evidence likely to lead to the deceased child's identification.**
**The deceased child is to be referred to as Child R.**

***Warning: The contents of this finding may be particularly distressing to some readers. Aboriginal and Torres Strait Islander peoples are warned that this finding refers to the death of a young person in the Kimberley region. References will be made to geographical locations however there will be no references to the young persons' name, to avoid causing offence or further distress to some readers.***

## INTRODUCTION

**1.** Child R died at Halls Creek Hospital on the evening of 5 January 2017 from the complications of an intestinal obstruction. She had been at Halls Creek Hospital since 6.55 am that morning. She was an Aboriginal child. She was 11 years old.

**2.** Child R had been born with a number of congenital abnormalities including an imperforate anus, which necessitated surgical interventions after her birth and during her childhood, to reconstruct her anus.

**3.** The surgeries were considered to be successful, but a consequence was that Child R frequently experienced chronic constipation of varying severity. Her health needs were complex, and she was on a regime of medical care and reviews with specialist paediatricians primarily arranged with her mother and with the assistance of her extended family. The family lived in Halls Creek.

**4.** On the morning of 5 January 2017 Child R's mother made the arrangements for her to be taken to Halls Creek Hospital's Emergency Department due to her having a very sore and swollen tummy, with vomiting. Over the day, two of the doctors at Halls Creek Hospital assessed Child R. They both had access to some relevant information about her past medical history.

**5.** Throughout the day, both Halls Creek Hospital doctors also sought the advice of the specialist paediatrician at Broome Hospital, who had greater knowledge of Child R's past medical history. As a result of those consultations and based upon the advice of the specialist paediatrician, it was decided to initially treat Child R locally at Halls Creek Hospital, rather than transferring her immediately to Broome Hospital.

**6.** From an early stage, the impression was that Child R's presentation was consistent with faecal loading due to longstanding constipation. Child R was admitted to the Halls Creek Hospital ward with a treatment plan involving enemas, anti-emetics and monitoring.

**7.** Child R's condition deteriorated throughout the day. After further consultation with the specialist paediatrician at Broome Hospital, Child R's admitting doctor contacted the Royal Flying Doctor Service for the purpose of transferring her to Broome Hospital. Her condition worsened and when the Royal Flying Doctor Service arrived at Halls Creek Hospital in the late afternoon of that day the on-board doctor considered that Child R was moribund and about to go into cardiac arrest.

**8.** Urgent attempts were made to stabilise Child R's condition, now for transfer to Darwin Hospital, due to it having an Intensive Care Unit. However, during transfer to the ambulance in preparation for evacuation out of Halls Creek, Child R's condition deteriorated even further, and CPR was commenced. Child R was swiftly returned to Halls Creek Hospital for resuscitation. Despite ongoing resuscitation efforts, she was not able to be revived. Tragically, she was pronounced dead on the evening of 5 January 2017.

**9.** Child R's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (WA) (the Act) and it was reported to the coroner as required by the Act. By reason of s 19(1) of the Act I have jurisdiction to investigate the death.

**10.** Child R's family requested an inquest into her death, under s 24 of the *Coroners Act* 1996 (the Act). Further investigations were undertaken, including the commissioning of an independent expert's report concerning Child R's medical care and treatment in the period leading to her death. On 7 January 2022 I determined that an inquest into Child R's death was desirable, within the meaning of s 22(2) of the Act to consider:

**(a)** whether there were missed opportunities to identify and treat Child R's condition when she presented to Halls Creek Hospital; and

**(b)** the challenges involved in the medical management of a child with complex care needs in a rural or remote area, having regard to the availability of medical care.

**11.** My primary function is to investigate the death. It is a fact-finding function. Under s 25(1)(b) and (c) of the Coroners Act, I must find, if possible, how death occurred and the cause of death.

**12.** Under s 25(2) of the Coroners Act, in this finding I may comment on any matter connected with the death including public health, safety or the administration of justice. This is the ancillary function.

**13.** Section 25(5) of the Coroners Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence. It is not my

role to assess the evidence for civil or criminal liability, and I am not bound by the rules of evidence.

**14.** I held an inquest into Child R's death between 5 and 7 July 2022. I heard from 9 witnesses and received 2 exhibits into evidence comprising 31 tabs.

**15.** After the inquest on 19 July 2022 additional evidence was drawn to the attention of the court by the State Solicitor's Office (SSO), namely the medical record of Child R's blood culture results taken on the afternoon of 5 January 2017. This record was taken into evidence as part of Exhibit 1, tab 5.1.

**16.** On 20 July 2022 the counsel assisting me at the inquest made submissions concerning potential findings and potential recommendations. On 4 August 2022 through her lawyer the Aboriginal Legal Service (ALS), Child R's mother made submissions concerning the evidence at the inquest. She informed the court that she felt let down by Halls Creek Hospital, and wished that things could have been done differently for Child R.

**17.** On 5 August 2022 I received information from the WA Country Health Service concerning the status of the State-wide electronic medical record. This information was taken into evidence as Exhibit 2, tab 30.9.

**18.** On 17 August 2022 I received further information concerning Child R's blood culture results. This information was taken into evidence as part of Exhibit 1, tab 5.1.

**19.** Also, after the inquest, through its lawyer the SSO, the WA Country Health Service provided a report from its Consultant Medical Director and colorectal surgeon Dr Michael Levitt (Dr Levitt) dated 22 August 2022, concerning the subsequently received blood culture results for Child R. This report was taken into evidence as Exhibit 2, tab 31.

**20.** Pursuant to s 44(2) of the Act, before I make any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

**21.** Between 23 August 2022 and 1 September 2022 submissions were made by the lawyers for the interested persons, for the purposes of s 44(2) of the Act, in connection with potential adverse findings and/or in connection with potential recommendations.

**22.** Further investigations were undertaken concerning the issues arising from Child R's blood culture results, referred to in Dr Levitt's report. On 10 March 2023 a report was sought from Dr Jodi White (Dr White), Consultant Forensic Pathologist and Head of Department, PathWest Laboratory Medicine WA, concerning those issues arising from Dr Levitt's report. Dr White provided her report dated 17 April 2023. It was taken into evidence as Exhibit 1, tab 5.2.

**23.** On 24 April 2023, the interested parties were provided with an opportunity to make submissions in connection with the matters outlined in Dr White's report dated 17 April 2023. Responses from the interested parties were received between 24 April 2023 and 15 May 2023.

**24.** In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361 - 362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

**25.** My findings appear below.

## CHILD R's MEDICAL BACKGROUND

**26.** Child R's death needs to be considered within the context of her medical background. Her medical records reflected that she frequently required medical care, including paediatric care.

### Pre-existing medical conditions

**27.** Child R's pre-existing medical conditions, arising from the need to surgically reconstruct her anus, were complex. Child R required ongoing medical assessments, with careful monitoring by her mother in her home environment. Child R's mother needed to be especially vigilant in order to monitor her chronic constipation and ensure as far as possible that she took her daily laxatives.

**28.** Child R's pre-existing medical conditions provide the context for her presentation at Halls Creek Hospital on 5 January 2017. It is my role to consider the standard and quality of medical care provided by Halls Creek Hospital to Child R on 5 January 2017.

**29.** After Child R's death the court sought and obtained a report from an independent expert, the Senior Consultant Paediatrician at Hedland Health

Campus, Dr Sathiaseelan Nair (Dr Nair), for his opinion on the quality of Child R's medical treatment and care.

**30.** Dr Nair provided his report to the coroner, and he gave evidence at the inquest.[1]

**31.** Immediately below is an overview of Child R's medical history insofar as it impacts upon the circumstances attending her death. It will be readily apparent that she had been in the care of a number of clinicians and that her mother, and family, were involved in taking her to numerous medical appointments and surgeries over the years and effectively caring for her in the home.

**32.** It is also the case also that on some occasions Child R's medical appointments were missed. This has been the subject of some comment in the evidentiary material, generally within the context of non-compliance.

**33.** Self-evidently for the optimal clinical outcome, medical appointments should be kept. However, for Child R, missed appointments should also be considered within the context of the family's difficult living circumstances. The devastating effects of intergenerational trauma continue to impact adversely upon the stability of some of the home environments within the Aboriginal communities.

**34.** I do not regard the missed medical appointments as indicative of a lack of care or concern for Child R on the part of her family. Later in this finding I comment upon the importance of a culturally responsive health service, that may encourage a greater and more confident engagement with clinicians. If this engagement is able to occur within the primary health care system, it may improve health outcomes and avoid emergency presentations.

**35.** I turn back to the impacts of Child R's pre-exiting medical conditions, and the review of her medical management and care by the independent expert Dr Nair. This requires an overview of Child R's medical history.

**36.** A day after her birth at Kununurra Hospital on 9 April 2005, Child R was transferred to Princess Margaret Hospital in Perth where she was noted to have anal atresia with a recto-vaginal fistula. The surgical repair of the fistula, with anoplasty, was carried out some months later at Princess

[1] Exhibit 1, tab 20; ts 212 to 275.

Margaret Hospital. This type of complex surgery could not be carried out at Halls Creek Hospital and required a temporary relocation to Perth.[2]

**37.** In the interim Child R had ongoing medical reviews at Halls Creek Hospital, and locally to her home, with her mother being responsible for daily dilatation of the fistulous tract pre-surgery and weekly dilatations of the anoplasty post-surgery. It was an onerous responsibility, and it was noted that Child R's mother, assisted by the grandmother, coped well with this. Other surgeries, including plastic surgery, were required. Child R also had a cardiac defect, namely a ventricular septal defect which was also corrected through surgery at Princess Margaret Hospital during her infancy.[3]

**38.** In his review of Child R's medical treatment over her first year of life (between 2005 and 2006) Dr Nair noted a few missed medical appointments, but that the majority were attended, and that overall Child R and her family were doing well.[4]

**39.** In her second year (between 2006 and 2007) Child R intermittently experienced poor growth. Over this period Child R continued to have ongoing medical reviews, including at Halls Creek Hospital. Upon the advice of the paediatric surgeon further complex surgery was planned for Child R's anal opening, as it had migrated (referred to as a cutback anoplasty).[5]

**40.** Dr Nair fully agreed with the paediatric surgeon's viewpoint concerning the surgery. He noted that Child R's mother wished to postpone the surgery for a few weeks and felt there could have been valid reasons as it necessitated travel to Perth, and a support person may have been needed. He remained of the view that at this stage, Child R continued to be appropriately managed.[6]

**41.** In her third year (between 2007 and 2008) Child R was seen by the Child Development and General Paediatrician, visiting in the Outreach Clinic. At this stage she had no history of constipation. The visiting paediatrician noted she was gaining weight and considered she was tracking well. However, Child R was not brought to the follow-up review later in the year. Over this period Child R was treated for some childhood infections and she

[2] Exhibit 1, tab 20.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.

was also seen and then discharged from the cardiology outreach clinic as she had recovered fully from the repair of her heart defect.[7]

**42.** Relevantly over this period, Child R's mother took her regularly to be seen by the Community Health Nurse at the Yiyili Clinic, a remote Aboriginal controlled health clinic staffed once a week. Here there were discussions about Child R's medications, with her mother reporting that she was taking them. This nurse was also able to assist with the Princess Margaret Hospital appointments. Dr Nair noted that there was an interagency meeting aimed at trying to encourage the family to consent to the further anal surgery that had been recommended by the paediatric surgeon, and he held no concerns for Child R's overall medical management during this period.[8]

**43.** In her fourth year (between 2008 and 2009) Child R underwent a surgical revision of her anoplasty with subsequent examination and anal dilatation under anaesthesia, at Princess Margaret Hospital. She was subsequently seen by clinicians in the outreach clinics, including by the visiting paediatrician. In his review Dr Nair noted that Child R's constipation started to become more of a problem in the latter part of 2009, and that her medications to assist with constipation were appropriately reviewed and altered. Dr Nair held no concerns for Child R's overall medical management during this period.[9]

**44.** In her fifth year (between 2009 and 2010) Child R experienced increasing episodes of abdominal pain with constipation. She presented to Halls Creek Hospital Emergency Department on a numerous occasions in 2010 for these symptoms, and required prescription laxatives. She did not present with vomiting in these instances. Dr Nair held no concerns for Child R's overall medical management during this period and noted that children in this age group will often refuse to take laxative medication because of the taste and palatability.[10]

**45.** In her sixth year (between 2010 and 2011) Child R's constipation became even more pronounced and clinicians looked for solutions. She experienced chronic faecal loading and was not wanting to take her medication for constipation (which as indicated is not unusual for children in this age group). The paediatricians who saw Child R reinforced the need for compliance with medications with Child R's mother. During one

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[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] Ibid.

presentation, a plan was made to transfer Child R to Derby Hospital for a bowel washout and records reflect that her mother did not support this. The Department of Communities were contacted regarding Child R's care. Child R's mother continued to take her to clinical appointments and her medications were reviewed. Towards the end of 2011 the specialist paediatrician referred her to the paediatric surgeon. Dr Nair considered this to be appropriate give Child R's escalating constipation.[11]

**46.** In her seventh year (between 2012 and 2013) Child R was seen a number of times by the Specialist Paediatrician who noted chronic faecal loading from constipation. Again, the importance of medications was reinforced with Child R's mother, and further consideration was given to Department of Communities involvement due to non-compliance with medications. Child R underwent a bowel washout at Broome Hospital in the latter part of 2012. In 2013, it was noted that her abdomen was much less distended, and her mother was regularly collecting her medications. Dr Nair held no concerns for Child R's overall medical management during this period and noted her improvement in 2013, her eighth year.[12]

**47.** In her ninth year (between 2013 and 2014) Child R experienced ongoing constipation. She presented at Halls Creek Hospital on a number of occasions, and she was treated with laxatives. The Specialist Paediatrician in consultation with the Paediatric Surgeon referred her to specialised continence services at Princess Margaret Hospital but unfortunately, while travel arrangements were made, the family missed the bus and was unable to travel to Perth. Dr Nair noted that Child R's mother continued to regularly collect her medication over this period.[13]

**48.** In her tenth and eleventh years (between 2015 and 2016) it is apparent that Child R's constipation became even more difficult to manage and there were numerous consultations with specialist clinicians. Unfortunately, there were some other medical and surgical appointments that were missed and on occasion the family was difficult to contact. Child R was not taken to see the Visiting Specialist Paediatrician in Halls Creek for her scheduled follow up visits in June and December 2016, though her mother attended on her own for the June 2016 visit and reported on Child R's progress.[14]

[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Ibid

**49.** Child R did attend at Princess Margaret Hospital in May 2016 for dental work. During this admission she was noted to be constipated and faecally overloaded. She underwent a bowel washout and anal dilatation while in hospital. A plan was made for her to return for further surgery, but she did not have the complex anal cutback surgery because her mother wished to postpone it. On this point, Dr Nair opined that the mother's approach was not completely unreasonable, having regard to the purpose of this surgery, and he noted the "*major pressures*" it would have placed on the mother, including the travel to Perth:

> "*In families living in very remote parts of Western Australia attendance at appointments is frequently difficult for various reasons and unfortunately missed appointments is a common occurrence*."[15]

**50.** Dr Nair drew the court's attention to the fact that on his review, the Patient Assisted Travel Scheme, operated through the WA Country Health Service, had not offered their support for one of the travels down to Perth for a scheduled appointment. He posited that this may have been due to medical staff not putting all relevant information on the application from and noted that it does occasionally occur due to pressures on clinical staff.[16]

**51.** Overall, Dr Nair considered Child R's medical care from 2005 to the end of 2016 to be of a satisfactory standard: "*especially given the complexities and difficulties generally experienced in providing optimal healthcare for children with complex and multiple medical problems in remote and rural communities*."[17]

**52.** Dr Nair noted that generally throughout her life Child R was promptly taken to Halls Creek Hospital for medical attention when unwell, and from 2011 onwards her mother attended there on multiple occasions to collect her medication.[18]

**53.** He also noted that there were numerous attempts made by the treating Paediatricians, Child Health Nurse, School Health Nurse and Princess Margaret Hospital to seek to engage with the family and encourage attendances at scheduled appointments.[19]

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[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Exhibit 1, tab 20.

**54.** The Specialist Paediatrician who treated Child R over the years made similar comments regarding the difficulties experienced by Aboriginal families in keeping appointments, and the difficulties experienced by clinicians when appointments are not kept. This was within the context of several missed appointments. The Specialist Paediatrician referred to attempts to contact Child R's mother and instances where the Halls Creek Hospital orderly would sometimes drive out to the community to attempt to locate her:

> "*A failure to attend clinic appointments was not unique to [Child R]. Non-attendance was a challenge with many patients in the region, despite the efforts of the multidisciplinary teams involved.*"[20]

**55.** The treating Specialist Paediatrician's overall view was that Child R's mother sought the required medical care for her and that her deterioration on 5 January 2017 was unexpected:

> "*I don't think that any of us could have predicted that [Child R] would go on to develop such an atonic bowel with severe faecal overloading because it was my previous experience [Child R's mother] had always been compliant to a degree about giving medication regularly to [Child R] and seeking medical assistance when required.*"[21]

## Engagement with Child Health Nurse

**56.** Child R's mother had experienced a positive engagement with the Child Health Nurse at Halls Creek. I address some aspects of this engagement as it shows the importance of ongoing consultations and care through the primary health care system, that may help to avoid repeat emergency presentations.

**57.** This Child Health Nurse had been employed by the WA Country Health Service at the Halls Creek Community Health Centre since 2008. She had had a longstanding contact with Child R and her family since that time. Most of that contact was at the Halls Creek Community Health Centre or the Halls Creek Hospital, until Child R was four years old. After that, it was the role of the School Health Nurse to provide the support for Child R and her family.[22]

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[20] Exhibit 1, tab 9.
[21] Ibid.
[22] Exhibit 1, tab 10.

**58.** Regrettably, when the School Health Nurse went on leave in March 2016, returning to work in May 2017, her position was not replaced throughout 2016. This contributed to some increase in the workload of the Child Health Nurse, who also undertook the role of Community Health Nurse. Nonetheless the Child Health Nurse continued to effectively carry out her role.[23]

**59.** The Child Health Nurse was aware that Child R was on medication for her bowels to avoid constipation, that she had had this condition since birth and that she had been treated at Princess Margaret Hospital. In her experience Child R's mother and her extended family were all aware of the importance of the medications and the consequences for Child R of not receiving them.[24]

**60.** The Child Health Nurse informed the court that Child R's mother would come into the Halls Creek Community Centre to ask for Child R's bowel medications when she ran out, and that the Child Health Nurse would go to Halls Creek Hospital, fetch the medication, and give it to her. The Child Health Nurse reported that Child R and her mother regularly came in to see her, and she would assist them.[25]

**61.** The Child Health Nurse informed the court that in May 2016, Child R's mother was anxious about travelling to Perth on her own, for Child R to be seen at Princess Margaret Hospital. When Child R was younger, the mother was provided with an escort, but as Child R became older, this service stopped.[26]

**62.** The Child Health Nurse (along with staff from Halls Creek Hospital) was also involved in seeking to persuade the mother to bring Child R to see the Visiting Paediatrician for scheduled follow up for her constipation and noted that some appointments in 2016 were missed. She recalled that Child R did not like going to Halls Creek Hospital and this posed difficulties for her mother in bringing her there.[27]

**63.** The Child Health Nurse last saw the family when she attended at their home in December 2016 in respect of another clinical consult and took the opportunity to remind the mother that Child R needed to be brought to the upcoming paediatric clinic to be seen by the Visiting Paediatrician.[28]

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[23] Ibid.
[24] Ibid.
[25] Ibid.
[26] Ibid.
[27] Ibid.
[28] Ibid.

**64.** Child R was not taken to Paediatric Clinic in December 2016. The Child Health Nurse then went on leave for four weeks. Child R died on 5 January 2017.[29]

**65.** The Child Health Nurse, who has considerable experience in the delivery of health services in Halls Creek, has highlighted the need for a service to provide ongoing support to high-risk families in Halls Creek, which includes families with medical concerns, a matter that she has advocated for. In her words:

> "*This is a tragic case which highlights a need for enhanced widespread community services to provide ongoing education and support to assist families with children with complex health problems and social issues and to arrange appropriate follow up*."[30]

**66.** Looking to the future, this would be an area where, in similar circumstances, a culturally informed care co-ordinator could be involved in assisting a child's family to navigate the various medical appointments (local and intra-state, GP and specialist, initial, follow up and surgical) and also advocate on behalf of a child's family. For example, advocate for an escort, if it was felt that anxieties about travelling to Perth for surgery may be relieved.

**67.** I have addressed the matter of a nurse practitioner, also known as a nurse navigator, for care co-ordination, in my *Recommendations*, later in this finding.

## PRIOR PRESENTATION TO HALLS CREEK HOSPITAL ON 4 JANUARY 2017

**68.** Child R's mother informed the court that on 4 January 2017 she took Child R to Halls Creek Hospital, because her daughter told her that she had pain in her back, and she was feeling bloated. In the days prior to that, Child R had been eating well and drinking plenty of water. Child R's mother informed the court that the hospital gave Child R a Movicol on 4 January 2017 and that they went home shortly afterwards.[31]

[29] Ibid.
[30] Ibid.
[31] Exhibit 1, tab 12.

**69.** There is no documentation in Child R's Halls Creek Hospital medical records reflecting a presentation on 4 January 2017. Handwritten notes relating to a family meeting held shortly after Child R's death, indicate that the family said Child R had been seen in the Halls Creek Hospital waiting room on or about 4 January 2017, the day before her death, that she was seen by a nurse, and was given paracetamol and Movicol. It was reported that she was not taken into triage for assessment.[32]

**70.** In his report to the coroner Dr Nair expressed his extreme concern about there being no documentation in Child R's medical records about her attendance at the Emergency Department of Halls Creek Hospital on 4 January 2017, noting that such documentation is vital in ensuring optimal healthcare and continuity of care. Dr Nair expressed these views on his understanding that Child R was taken to Halls Creek Hospital on 4 January 2015 as outlined by her mother.[33]

**71.** A prior recent hospital attendance or repeat hospital attendance(s) by a patient, is a matter that hospital clinicians will take into account. It can reflect upon the severity of the presentation and give the doctors some insight into a patient's condition.

**72.** If Dr Allen and Dr Ramasamy had information before them to the effect that Child R's presentation on 5 January 2017 was the second presentation to the hospital within 24 hours, it would likely have elevated their concerns about her condition when they reviewed her on 5 January 2017. Dr Ramasamy felt that with this additional information, the treating team would have accelerated their request for Child R's transfer out of Halls Creek on 5 January 2017.[34]

**73.** Through her lawyer the ALS, Child R's mother submits that Child R attended at Halls Creek Hospital with her on 4 January 2017, that Child R was not examined by a staff member on that occasion, that this was a significant missed opportunity for early intervention into Child R's condition, and that it significantly impacted the treatment that Child R received and hospital the following day.

**74.** Through their lawyer the SSO, the WA Country Health Service submits that there is insufficient evidence to support a finding that Child R attended at Halls Creek Hospital with her mother on 4 January 2017.

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[32] Exhibit 1, tab 12.
[33] Exhibit 1, tabs 12 and 20.
[34] ts 49 and 112.

**75.** Whilst there is no record of Child R (or her mother on her behalf) attending at Halls Creek Hospital on 4 January 2017, Child R's medical record does reflect that her mother attended at Halls Creek Hospital (without Child R) at approximately 5.00 pm on 3 January 2017 and that she saw Dr Rajkumar Ramasamy (Dr Ramasamy).[35]

**76.** Dr Ramasamy informed the court that this consult was in respect of another child, but that at the end of the consult Child R's mother sought laxative medications for Child R. It is noted in the medical record that Child R's mother asked Dr Ramasamy for one month's supply of Movicol, that she was instead supplied with 10 days' worth of Movicol, that she was advised that Child R needs a GP review and advised to make an appointment.[36]

**77.** In her report to the coroner Dr Sue Phillips (Dr Phillips), Regional Director of Medical Services with the WA Country Health Service reiterated that there are no documents held by that entity that confirm Child R attended Halls Creek Hospital on 4 January 2017. Dr Phillips informed the court that administering Movicol to a child without a medical practitioner's written or verbal order would have breached the Medication Administration Policy applicable at the relevant time. I consider it unlikely that a nurse gave Child R's mother Movicol on 4 January 2017 without a medical practitioner's written or verbal order, in apparent breach of the policy.[37]

**78.** Dr Phillips reported that she was unable to definitively state whether Child R did or did not attend Halls Creek Hospital on 4 January 2017.

**79.** There is insufficient evidence before me to determine whether or not Child R attended at Halls Creek Hospital on 4 January 2017 with her mother. I am however satisfied that Child R's mother did attend (without Child R) on 3 January 2017, to request Movicol for Child R (most likely because she had run out of it) and that 10 days' worth of Movicol appears to have been provided to Child R's mother by Dr Ramasamy on that date (based on the medical record made on 3 January 2017).[38]

**80.** If that additional attendance on 4 January 2017 did occur, it should have been recorded in Child R's medical notes, along with a record of the dispensing of any further medication. It is unlikely that more Movicol would have been dispensed again by a nurse on 4 January 2017 (in apparent

[35] Exhibit 1, tab 24.
[36] Exhibit 1, tabs 23 and 24; ts 122.
[37] Exhibit 1, tab 24; Exhibit 2, tab 30.
[38] Exhibit 1, tab 24.

breach of policy), when 10 days' worth had already been dispensed by the doctor on 3 January 2017.

**81.** Dr Phillips reported to the court that the WA Country Health Service's inquiries into the matter of Child R's prior hospital attendances are ongoing. This is important within the context of clinical governance and serves to reinforce the importance of record keeping.

## TREATMENT AT HALLS CREEK HOSPITAL ON 5 JANUARY 2017

### Initial presentation

**82.** Child R was feeling unwell at the beginning of the day on 5 January 2017. Child R's mother could see that her tummy was swollen, and she made the arrangements for the Halls Creek Hospital orderly to collect them early that morning and bring them to the hospital.[39]

**83.** Child R and her mother arrived at the Emergency Department of Halls Creek Hospital at 6.55 am on 5 January 2017. Her mother reported to the nurse that she had vomited once after breakfast and had opened her bowels that morning. Child R was in pain, her abdomen was distended, and she looked very unwell.[40]

**84.** The nurse who initially saw Child R in the Emergency Department at 6.55 am recorded the following observations:

- **(a)** Temperature: 36 degrees Celsius;
- **(b)** Pulse: 153 beats per minute;
- **(c)** Blood pressure: 90/20 mm Hg;
- **(d)** Respiratory rate: 24 breaths per minute;
- **(e)** Oxygen saturations: 98%.

**85.** These reflected that her pulse rate was elevated, and her blood pressure was at the lower end of the normal range, with the rest of the observations being within the normal range.

**86.** Child R's initial dehydration score revealed mild dehydration. She was given a Triage Score of 3. On the Australian Triage Category Scale, it meant she should have been seen within 30 minutes.[41]

[39] Exhibit 1, tab 13.
[40] Exhibit 1, tabs 12, 13, 20 and 24.
[41] Exhibit 1, tabs 20 and 24.

**87.** Child R was seen by a second nurse 20 minutes later at 7.15 am. These nursing notes record that Child R had presented with a distended abdomen and that she had opened her bowels five times the previous day, with one episode of vomiting in the morning. Child R was still agitated, and Dr Allen was called straight away to review her.[42]

**88.** On his subsequent independent review of Child R's care and treatment, Dr Nair considered that Child R was appropriately triaged and seen within the recommended time.[43]

## Dr Allen's first review

**89.** Dr Allen attended to review Child R at approximately 7.42 am (she was the doctor on call until 8.00 am). Child R looked very sick to her. Dr Allen had not previously seen Child R, and she initially obtained a history from Child R's mother, as Child R was not able to respond to her questions. Child R appeared to have an altered mental state and Dr Allen interpreted that as being due to longstanding intellectual disability.[44]

**90.** Dr Allen was not aware that this was, potentially, Child R's second presentation in 24 hours. Had she been so aware, it would have increased the level of her concern.[45]

**91.** Child R's mother reported to Dr Allen that Child R had one vomit after breakfast, her abdomen had been increasingly swollen over a few days, and she had had a few abnormal bowel motions over the previous two days.[46]

**92.** Dr Allen asked Child R's mother whether Child R had had a fever or infectious illness, as she was thinking of the possibility of sepsis. She queried the extent of the vomiting, the pain, and the bowel motions, as she was also considering whether there were signs of bowel obstruction. They were broad differential diagnoses, given the history of vomiting in a child that looked to her as unwell as Child R.[47]

**93.** Dr Allen made a physical examination of Child R noting that her abdomen was distended but not tender, and that there were bowel sounds present. She

[42] Exhibit 1, tabs 13, 20 and 24.
[43] Exhibit 1, tab 20.
[44] Exhibit 1, tab 13; ts 9 to 12.
[45] ts 49.
[46] Ibid.
[47] Ibid.

commenced a discussion with Child R's mother about the possibility of a transfer to Broome Hospital. Dr Allen formed the view that Child R's mother did not believe she required the transfer. Dr Allen's recall was that Child R's mother felt that Child R was constipated, but that she was otherwise "*fine*" having had breakfast and taken fluids.[48]

**94.** Child R's longstanding constipation had primarily been managed with Movicol sachets, to be taken regularly. Child R's mother reported to Dr Allen that Child R had stopped taking the Movicol sachets in November 2016 and had recommenced them recently. A concern for Dr Allen at this stage was to identify whether Child R's condition was attributable to constipation, or more seriously, a bowel obstruction.[49]

**95.** Dr Allen had not previously treated a child with a bowel obstruction. She is a GP and as would be expected, she made the arrangements to consult over the telephone with the more senior Consultant Paediatrician at Broome Hospital, Dr Kuria Nemba (Dr Nemba).[50]

**96.** Dr Nemba had previously seen Child R at Broome Hospital in 2012, when she had massive faecal loading with abdominal fullness, requiring a bowel washout. He was aware that Child R had been born with multiple complex birth defects, and that she had undergone a surgical repair and reconstruction of her anus. To his knowledge the result was that she did not have the normal pattern of bowel control and was permanently constipated.[51]

## Dr Allen's consultation with Dr Nemba

**97.** Dr Allen contacted Dr Nemba and spoke with him over the telephone at approximately 8.30 am on 5 January 2017. There is some difference in recall regarding the detail of the conversation as between Dr Allen and Dr Nemba. The differences are not entirely unexpected given that these conversations can typically held on an urgent basis in high workload environments.[52]

**98.** I am satisfied that during her conversation with Dr Nemba, Dr Allen outlined the results of her clinical observations and examination of Child R concerning the abdominal pain and distension, the recent history of her bowel motions and vomiting, and provided background information

[48] Ibid.
[49] Exhibit 1, tab 13; Exhibit 2, tab 29.
[50] Exhibit 1, tabs 13 and 29; ts 22; ts 175 to 176.
[51] Exhibit 2, tab 29.
[52] Exhibit 1, tab 13; Exhibit 2, tab 29; ts 30 to 38.

concerning Child R's medications (including the cessation of regular Movicol in November 2016) and the cancelled surgical appointment for the revision of anoplasty at Princess Margaret Hospital.[53]

**99.** I am also satisfied that Dr Allen conveyed her concern about Child R's condition to Dr Nemba. He was informed that Child R was screaming in pain and that she might be obstructed. The conversation was about whether Child R should be transferred to Broome Hospital. Dr Allen did not feel she could manage Child R in Halls Creek, citing several factors including the fact that she could not do an abdominal ultrasound or an x-ray at Halls Creek Hospital.[54]

**100.** On the basis of the information given to him, Dr Nemba provided his advice to Dr Allen. He told Dr Allen that Child R probably had faecal loading from chronic constipation (noting the information that she had not been taking her laxative medications for some time). At that stage it was not clear to him that Child R had a bowel obstruction, toxic megacolon, or other conditions.[55]

**101.** Whilst Dr Nemba considered that bowel obstruction might be a possibility, he wanted an initial step to be taken, with a call back if it did not work. He recommended that Child R be admitted to Halls Creek Hospital with the initial step being the commencement of treatment with a phosphate enema to ascertain if it would assist with the removal of the impacted faeces. It appears Child R may already have been given a Microlax enema, without favourable results. Alternatively, it may have been administered by Dr Allen after her discussion with Dr Nemba, again without the favourable results.[56]

**102.** It is not necessary to resolve this question because, in any case, Dr Nemba informed Dr Allen that a phosphate enema is a "*bit stronger*", and that was his recommended treatment. The plan was for him to be called back if the phosphate enema did not work. In Dr Nemba's experience it should not take more than half an hour for results.[57]

**103.** Dr Allen had a concern about sepsis from an early stage though the extent to which this was specifically raised by her with Dr Nemba is unclear. Dr Allen testified that the differential diagnoses that she was exploring with Dr Nemba were bowel obstruction and faecal loading. She recalled the sepsis being mentioned in two ways, namely in connection with the

[53] Exhibit 1 tabs 13 and 24; Exhibit 2, tab 29.
[54] Exhibit 1 tabs 13 and 24; Exhibit 2, tab 29; ts 14 to 15; ts 133 to 136.
[55] Exhibit 2, tab 29; ts 133 to 136.
[56] Exhibit 1, tabs 13 and 24; Exhibit 2, tab 29; ts 133 to 136.
[57] Exhibit 1, tab 13 and 24; Exhibit 2, tab 29; ts 133 to 136.

tachycardia, and by reference to the question of whether blood tests should be done. Dr Nemba could not recall whether the elevated heart rate and borderline low blood pressure were raised by Dr Allen with him in that first conversation they had together. At the inquest he stated that he did not keep notes of this conversation and that while he was prepared to assume they were raised with him, the fact remains that he did not specifically recall them being raised.[58]

**104.** Dr Nemba did not recommend blood tests at this stage. He wanted to see the outcome of the phosphate enema, because a result one way or the other would be seen within half an hour. If the result was not favourable, then treatment could be directed towards another condition. At the inquest he agreed that blood tests could have been done at the same time as the phosphate enema, having now the opportunity to consider the issue in hindsight.[59]

**105.** Dr Allen testified that she found Dr Nemba to be reassuring during that telephone conversation, because she was feeling "*quite alarmed*" at how unwell Child R was becoming. A question arose as to whether Dr Allen should have been firmer in her discussions with Dr Nemba and essentially asserted to him that Child R be urgently transferred from Halls Creek Hospital to Broome Hospital during this 8.30 am telephone discussion, before implementing his recommended treatment.[60]

**106.** Through her lawyer the ALS, Child R's mother submits this was a missed opportunity to have Child R admitted to Broome Hospital as soon as possible. In her report to the coroner, Dr Phillips referred to improvements in the areas of training for clinicians, including graded assertiveness skills, that she thinks may have assisted Dr Allen in her communications with Dr Nemba.[61]

**107.** While in hindsight a more assertive approach by Dr Allen may have been preferable, care must be taken not to assume that the existence of the bowel obstruction was more predictable at the material time. I take into account that Dr Allen was communicating with a more senior specialist colleague, who had knowledge of Child R's past clinical history. Dr Nemba gave a reasonable response, which was to first see whether the phosphate enema would work.[62]

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[58] Exhibit 2, tab 29; ts 17; s 20; ts 31 to 32; ts 60; ts 176 to 178.
[59] ts 153 to 154.
[60] ts 22.
[61] Exhibit 2, tab 30.
[62] ts 153 to 154.

**108.** Unfortunately, the phosphate enema was not promptly given in accordance with Dr Nemba's advice. Specifically, it was not given until approximately 11.40 am that day, some three hours after Dr Nemba recommended it, and the delay in administering the phosphate enema represents the missed opportunity.

**109.** The matter was further complicated by Dr Allen having gained the impression that Child R's family did not want her transferred to Broome. Through its lawyer the SSO, the WA Country Health Service (WACHS) submits to me that this was one of the reasons why it was not possible to arrange a transfer with the Royal Flying Doctors Service (RFDS) at 8.30 am. However, a more culturally informed inquiry, supporting both the family and Dr Allen in her understanding about the family's misgivings, might have assisted in resolving this matter at an earlier stage.[63]

**110.** In evidence Dr Allen testified as to her feeling that she was not in a position to disagree with Dr Nemba, and transfer Child R to Brome Hospital. In the circumstances, and in light of her skills and training, that is understandable. In any event she was not able to override him and unilaterally make the decision to transfer Child R to Broome Hospital.[64]

**111.** Dr Allen described Dr Nemba's response to her as him having "*pushed back*" in their 8.30 am telephone conversation. I have considered this issue and the evidence before me as to the interaction. I turn back to the clarity of Dr Nemba's advice – give the phosphate enema and ring back if it does not work. I do not consider him to have "*pushed back*". Rather he has proposed a course of action, which if implemented, was likely to quite promptly indicate whether it was a case of impacted faeces, or something more worrying and serious, such as a bowel obstruction. In their telephone conversation, Dr Allen agreed to undertake this recommended course of action.[65]

**112.** At the inquest the question arose of whether there had been a premature diagnostic closure in this 8.30 am telephone conversation between Dr Allen and Dr Nemba, and whether their discussions were affected by cognitive biases. For example, whether Child R's presentation at Halls Creek Hospital on 5 January 2017 was thought to be like many of her previous presentations, of her being constipated and faecally overloaded. For

[63] Exhibit 1, tab 13.
[64] ts 40 to 41.
[65] ts 40 to 41.

example also, whether their conversation was clouded by discussions concerning past instances of non-compliance with recommended medical treatments for Child R.[66]

**113.** I have considered Dr Nair's exploration of the points of difference between past presentations and this presentation to Halls Creek Hospital. On the 5 January 2017 presentation:

(a) Child R looked clinically unwell; she had previously been seen many times with abdominal pain and distension and constipation, but there was no prior recorded history of her looking clinically unwell; and

(b) Child R had vomiting that persisted despite the administration of an antiemetic.[67]

**114.** In Dr Nair's opinion, there should have been an active search for the medical cause of the vomiting whereas the focus was mainly on the constipation:

> "*When the vomiting is combined with the marked abdominal distension, a child looking unwell and distressed and persistent tachycardia and borderline low blood pressure, causes such as acute bowel obstruction or bowel perforation must be actively looked for and further investigations considered….*"[68]

**115.** In Dr Nair's experience "*vomiting is certainly not part of the clinical picture*" where children with chronic constipation are admitted to paediatric wards for a bowel washout for faecal overloading. Dr Nair pointed to further investigations such as blood tests and abdominal x-ray or ultrasound, given the clinical presentation.[69]

**116.** In hindsight there ought to have been an active search for the cause of the recurrent vomiting, given that it continued. I take into account the fact that, at Halls Creek Hospital, Child R was seen by GP's, who did not have the level of experience expected of a Consultant Paediatrician. I also bear in mind that at the stage of the 8.30 am telephone conversation, Dr Nemba had been informed by Dr Allen that Child R had vomited once at home, and possibly also informed she had vomited once at the hospital.[70]

[66] Exhibit 1, tab 20; ts 153 to 154.
[67] Exhibit 1, tab 20.
[68] Ibid.
[69] Exhibit 1, tabs 20 and 24; Exhibit 2, tab 29.
[70] Exhibit 1, tab 13; Exhibit 2, tab 29; ts 30 to 32.

**117.** It is not clear whether Dr Nemba was specifically informed that Child R looked clinically unwell, but it is clear to me that Dr Allen conveyed concern about Child R to him.

**118.** I turn back to a critical issue, being why the phosphate enema was not promptly done in accordance with Dr Nemba's recommendation, with a call back to him if it did not work to open Child R's bowels. Dr Nemba informed the court that if the phosphate enema did not resolve the issue, he would have recommended further inquiries, including the taking of bloods.[71]

**119.** After the 8.30 am telephone call between Dr Allen and Dr Nemba, Dr Allen did chart the phosphate enema (one to two times daily) to be given on the ward, as well as further medications and treatment to assist with vomiting and constipation. Child R was duly admitted to the ward at approximately 9.00 am, and treatment began, but the phosphate enema was not promptly given. Child R's repeat observations showed that her heart rate was still elevated (145 beats per minute).[72]

**120.** Dr Allen explained that at the time of admission to the ward Child R was vomiting and uncomfortable. Dr Allen wanted Child R to be medicated for her pain and vomiting, before the phosphate enema was given, for compassionate reasons. A phosphate enema can cause quite a painful contraction of the abdomen. Dr Allen asked the ward nurse to give the phosphate enema, and it was her expectation that it would have been done within the next hour, after the pain relief and antiemetic medications had their effects (though she did not document a time for it to be given).[73]

**121.** At around this stage, or shortly beforehand, Dr Allen completed her shift on the Emergency Department. She then left to perform her allocated duties at the GP Outpatient Clinic at Halls Creek Hospital. Before leaving, Dr Allen reported that she spoke with Dr Ramasamy, who had taken over from her to cover the Emergency Department. There was some inconsistency in the evidence as between them, as to whether this conversation occurred and if so, whether in the course of it, Dr Allen handed over the care of Child R to Dr Ramasamy. This is addressed in more detail later in this finding under the heading: *Handover of Child R's medical management*.

**122.** The phosphate enema was not given by the nurse within an hour of Child R's admission to the ward. There were reasons for this. Child R continued

[71] Exhibit 1, tab 29.
[72] Exhibit 1, tabs 20 and 24.
[73] ts 40 and 54.

to vomit, her abdomen continued to appear distended, and her family was, understandably, agitated. Child R remained agitated.[74]

**123.** At this stage, if continuity of care had been successfully achieved, there should have been a call back to Dr Nemba to say that the phosphate enema cannot reasonably be administered, Child R's agitation and vomiting had worsened, and a firm recommendation made for transfer to Broome Hospital. Unfortunately, this continuity of care was not achieved, and this is further addressed under the heading: *Handover of Child R's medical management*.

**124.** Turning back to the events of that day, the clinical nurse manager on the ward was concerned about Child R's condition, approached Dr Allen and also requested that Dr Ramasamy review Child R, having consulted with another nurse, who also felt that Child R needed to be flown out of Halls Creek for better management and treatment.[75]

**125.** Before addressing Dr Ramasamy's review of Child R, it is relevant to consider which doctor, at this stage, was responsible for Child R.

## Admission of Child R to the ward

**126.** Child R was admitted to the ward at approximately 9.00 am under Dr Allen's name. The normal course is that the doctor who manages the patient in the Emergency Department and admits the patient on the ward (being Dr Allen in both cases) would manage the patient on the ward.[76]

**127.** However, Dr Allen was required to attend to her duties at the GP Outpatient Clinic attached to Halls Creek Hospital at 9.00 am. Self-evidently, patients requiring emergency treatment are not admitted to the ward. Dr Allen herself explained the usual process is to admit a patient who is stable to the ward, for example a patient who would only need a review once a day, or a review at the end of the day and then at the beginning of the next day: "*If you're needing a review more than twice a day, it begs the question why are you being admitted to Halls Creek Hospital*?"[77]

**128.** Nonetheless Child R was admitted to the ward. Dr Allen explained that she was new in her role, it being her third week in Halls Creek, and that she had

[74] Exhibit 1, tabs 14 and 20.
[75] Exhibit 1, tab 14.
[76] Exhibit 1, tab 23; ts 57.
[77] ts 32.

already been reprimanded about spending too long with Emergency Department patients when she was due to perform her duties at the GP Outpatient Clinic. She felt that in admitting Child R to the ward, she was acting in accordance with Dr Nemba's advice. She wanted someone to take over the care of Child R in the ward. Essentially, she wanted some help, and she looked to Dr Ramasamy, who had had a longer experience at Halls Creek Hospital.[78]

**129.** Within the context of the capacity at Halls Creek Hospital, Dr Ramasamy informed the court that their Emergency Department had limited capacity to retain patients for long periods. In his experience, after assessment the patients either have to be admitted to the ward, discharged or transferred out to another medical facility.[79]

**130.** The question arose of whether Child R should have remained in the Emergency Department of Halls Creek Hospital, instead of being admitted to the ward.

**131.** I have had regard to the opinion of the independent expert, senior Consultant Paediatrician Dr Nair, regarding this question. Dr Nair, drawing on his experience of over 25 years, testified as to the general approach that:

> "*….putting an unstable child on the ward …. is fraught with difficulties and unfortunately outcomes are not good, because [of] there's other patients on the ward, nursing staff are busy …. and the emergency department is geared towards resuscitation ….*"[80]

**132.** At the inquest Dr Nair's attention was drawn to the fact that in this case, the Emergency Department and the ward were in proximity (potentially a 10-metre distance). Dr Nair clarified that he had no criticism of Dr Allen's decision to admit Child R to the ward, having regard to the proximity. Looking to the future however, Dr Nair felt that it is important to understand the resourcing of the ward (for example patient to nurse ratios), and that an Emergency Department is also more geared towards stabilisation.[81]

**133.** The factors potentially affecting the transfer from the Emergency Department to the ward were also considered by Dr Phillips, Regional

[78] ts 19; ts 32.
[79] ts 126.
[80] ts 263.
[81] ts 274 to 275.

Director of Medical Services with the WA Country Health Service, who provided a report to the coroner and gave evidence at the inquest.[82]

**134.** Dr Phillips' evidence was that an unstable child such as Child R should have stayed in the Emergency Department, referring also to the reasons expressed by Dr Nair (some of which he gave within the context of future improvements). In expanding on the importance of keeping a patient who is unstable in the Emergency Department, for frequent monitoring, treatment, assessment and reassessment, Dr Phillips informed the court as follows:

> "*…. that is what is frequently done in our ED's in the Kimberley, because that's where the monitoring is able to be done. A ward based environment …. doesn't have central monitoring. So there might be a small dash monitor that is next to the patient, that is in the room with the patient, but [it's] not being seen by anybody. So they need to be visible, because they're going to need frequent review.*"[83]

**135.** Through her lawyer the ALS, Child R's mother submits that Child R's treatment may have had different outcomes if she had remained in the Emergency Department rather than being transferred to the ward. Child R's mother submits that the transfer to the ward led to further delays in her treatment.

**136.** I accept this submission, especially in light of the further submission of WA Country Service through its lawyer the SSO, about the role of Dr Allen, a rural generalist, responsible for both patients in the ward and patients at the GP Outpatient Clinic (addressed in more detail under the heading: *Dr Allen's working conditions*).

**137.** I have noted the WA Country Health Service's submission though its lawyer the SSO, about Child R being moved twice over the period of her admission, to allow for increased monitoring. This was appropriate in the circumstances, though it may not have been necessary, had she remained in the Emergency Department.

**138.** I am satisfied that Child R should have remained in the Emergency Department, where she could have been more closely monitored, on an ongoing basis.

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[82] Exhibit 2, tab 30; ts 278 to 312.
[83] ts 294 to 295.

### Handover of Child R's medical management

**139.** As outlined earlier, Dr Allen reported that before she left to attend the GP Outpatient Clinic, she spoke with Dr Ramasamy. Dr Allen's evidence was that she left that conversation having formed the impression that she had handed the care of Child R over to Dr Ramasamy. She testified that she handed over to Dr Ramasamy because she was worried about Child R's wellbeing and thought that if her observations had not improved, they needed to call back Dr Nemba in Broome to say she needs transfer. She believes she asked Dr Ramasamy to review Child R and she felt that he reluctantly agreed to do so.[84]

**140.** Having regard to the subsequent confusion over which doctor was responsible for Child R's care on the ward, Dr Allen posited that in retrospect, during that conversation Dr Ramasamy had been politely declining to take over Child R's care without her realising it, and therefore she characterised it as a misunderstanding as between them.[85]

**141.** Dr Allen's recollection was that this conversation between her and Dr Ramasamy took place shortly after 9.00 am, after Child R had been administered medication for her pain and vomiting, after she had been admitted to the ward, but before the administration of the phosphate enema. She recalled they were both in the Emergency Department area, which was close to the ward area.[86]

**142.** In contrast, Dr Ramasamy's evidence was that he did not recall this conversation with Dr Allen. He recalled being asked by the nursing staff on the ward to review Child R at 9.30 am (not earlier). This is consistent with the 9.30 am note he made in Child R's medical records to the effect that he was asked to see Child R because the family was agitated, and Dr Allen was busy.[87]

**143.** It is also broadly consistent with the evidence of the clinical nurse manager on the ward who informed the court that, after 9.30 am he reached out to Dr Ramasamy, the next available medical officer in the building because he wanted another opinion on Child R, given that Dr Allen had not responded favourably to his expressed concern about Child R urgently needing to be

[84] ts 19.
[85] ts 58.
[86] ts 58 to 60.
[87] Exhibit 1, tab 24; ts 125.

flown out to another medical facility with higher capabilities. This aspect is addressed on more detail under the heading: *Dr Ramasamy's review*.[88]

**144.** Dr Allen's retrospective medical note, written at 8.30 pm that night, does not document a handover from her to Dr Ramasamy, though in the course of outlining the events of the day, the note refers to his assistance and help with Child R on specific matters.[89]

**145.** At the inquest Dr Phillips was asked for her view about handover of clinical care within the context of responsibility for Child R. Noting that Child R was initially in Dr Allen's care, she said Dr Allen bore that responsibility, while Child R was in her care. When it comes to a handover, Dr Phillips view was that it has to be: "*…. firmly recognised that that was a handover process*."[90]

**146.** The evidence before me raises the question of whether there was a handover from Dr Allen to Dr Ramasamy, and if so, when.

**147.** I accept the submission from Dr Ramasamy, through his lawyer, that responsibility for a patient's ongoing management involves more than just speaking to another doctor (or even asking that doctor for help). A handover needs to be documented and made known to the other clinical staff.

**148.** It is concerning that a clinically significant event such as a handover, was and remains a matter of some uncertainty. Through her lawyer the ALS, Child R's mother submits that there was a failure to communicate that led to neither doctor considering themselves responsible for Child R between 8.30 am and 9.30 am.

**149.** I accept that submission, to the extent that the commencement of the period of uncertainty ranges from 8.30 am or 9.00 am.

**150.** In either case, the uncertainty is unsatisfactory. The unfortunate outcome was that between approximately 8.30 or 9.00 am on the one hand, and 9.30 am on the other hand, a critical period in terms of continuity of care, it remains unclear who, as between Dr Allen and Dr Ramasamy, was responsible for Child R's medical care and treatment, with neither of them considering they were responsible.

[88] ts 68 to 69.
[89] Exhibit 1, tab 24.
[90] ts 294.

**151.** This was the time when a phosphate enema should ideally have been administered, with a call back to Dr Nemba if it did not work (or a call back to him if it could not reasonably be administered).

## Delay

**152.** The consequences of lack of clarity around the handover of Child R's medical care were magnified because time was of the essence. Child R was unstable and required monitoring, and, as indicated above, required the urgent administration of a phosphate enema, with a call back to Dr Nemba if it did not work.

**153.** Through her lawyer the ALS, Child R's mother submits that Dr Nemba, in wanting to first rule out faecal impaction by means of a phosphate enema, may have been impacted by premature diagnostic closure. Dr Nemba had previously treated Child R. My attention is drawn to his evidence, in particular his testimony that he felt he knew "*the most likely cause*" (at the material time) and that he refused to accept the transfer of Child R to Broome Hospital until he knew the outcome of the phosphate enema.[91]

**154.** In his written report to the coroner the independent expert Dr Nair had canvassed the issue of "*cognitive biases*" within the context of Child R's previous presentations to Halls Creek Hospital of her being constipated and faecally overloaded, potentially leading to an assumption that this presentation on 5 January 2017 was like many of her previous ones.[92]

**155.** Dr Nair explained that a simple way of ensuring that cognitive biases are kept in check is to have a list of differential diagnoses when patients present with medical problems. In his written report he posited that in Child R's case it was assumed that the chronic constipation with faecal overloading accounted for her persistently elevated heart rate, vomiting, marked abdominal distension and borderline blood pressure.[93]

**156.** With the benefit of his considerable experience, Dr Nair suggested that differential diagnoses may have included an intercurrent infection such as gastroenteritis, toxic megacolon, intestinal obstruction, bowel perforation, chronic constipation with a coexisting urinary tract infection. This would

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[91] Exhibit 2, tab 29;
[92] Exhibit 1, tab 20.
[93] Ibid.

have prompted active investigations to exclude the serious and potentially life-threatening ones.[94]

**157.** At the inquest Dr Nair considered this issue in light of the evidence and Child R's complex background. He felt he would probably have given Child R a trial of an enema, given it half an hour to work, and also given her some analgesia to take her pain away. While awaiting the outcome of the enema, he would have kept monitoring her heart rate (that was elevated) and blood pressure (that was borderline low) and would have turned his mind to dehydration, given an IV bolus of fluid and continued further investigations that he outlined in evidence. Essentially Dr Nair's evidence supported the initial approach, which was to trial the phosphate enema.[95]

**158.** At the inquest Dr Nair gave further consideration to the question of whether "*unconscious bias*" or "*cognitive biases*" played a part in Child R's medical treatment, and he was questioned on these matters. Ultimately Dr Nair formed the view that they did not play a part.[96]

**159.** This was within the context of there being a better indication of a bowel obstruction when faeculent vomiting was first noted, which was at approximately 11.00 am. Dr Nair felt that at this stage, the indication of a bowel obstruction became a lot clearer.[97]

**160.** At the inquest Dr Phillips' evidence was to the effect that the phosphate enema took too long to be administered. Within this context Dr Phillips testified as to reasoning for the phosphate enema follows:

> "*…. the reason the child is there is because the child is sick. The reason the child is sick is because it has got, you know, a kilo and a half of faeces impacted. You have to address the underlying cause, and the underlying cause needed an enema to at least try to shift it, and if you couldn't shift it, then bowel washout in Broome. Very simple.*"[98]

**161.** It remains unclear as to why Dr Nemba's advice to administer the phosphate enema was not followed at (or close to) the time that he gave that advice. In her report to the coroner Dr Phillips informed the coroner that in her opinion, attempting the usual treatments to the clear the faecal blockage was

[94] Ibid.
[95] ts 251 to 252.
[96] ts 273 to 274.
[97] Exhibit 1, tab 24; ts 258.
[98] ts 295.

reasonable, given that Dr Nemba had known them to work in the past for Child R.[99]

**162.** However, while Dr Phillips considered that Child R's management plan and initial working diagnosis was reasonable, she also felt that the management plan at Halls Creek Hospital could have been improved if it had included:

(a) A documented, planned review time for Child R; and

(b) Instructions on how urgently the phosphate enema was to be administered.[100]

**163.** Through its lawyer the SSO, the WA Country Health Service submits that the initial management plan for Child R by the clinicians was appropriate, and I accept that. However, taking account of Dr Phillips evidence, I am also satisfied that it could have been improved, in respect of the two aspects referred to immediately above, especially the instructions on the urgency.

**164.** At the inquest Dr Phillips was asked for her view on why the phosphate enema took too long to be administered. Dr Phillips pointed to the time taken for the paperwork to be completed for a patient such as Child R to be admitted to the ward, in order for the nurses to have the information to look after the patient, and the need to go through the document with the child's mother, as potential factors affecting the delay in administration.[101]

**165.** Through its lawyer the SSO, the WA Country Health Service accepts that the delayed administration of the phosphate enema delayed Child R's management at 11.00 am. This is further addressed later in this finding, under the heading *Dr Ramasamy's consultations with Dr Nemba*, that occurred at approximately at 11.00 am.

**166.** However, I am also satisfied that the delayed administration of the phosphate enema delayed Child R's management even earlier than 11.00 am (and continued to have this effect at 11.00 am).

**167.** The delayed administration of the phosphate enema delayed Child R's management shortly after Dr Nemba gave that advice in the 8.30 am telephone conversation with Dr Allen. It is unnecessary to place a precise time on it; it suffices to say that shortly after Dr Nemba gave that advice, the

[99] Exhibit 2, tab 30.
[100] Ibid.
[101] ts 295 to 296.

phosphate enema should have been administered, or there should have been a prompt call back to him to advise that it could not reasonably be administered.

**168.** The factors contributing to this delay include the uncertainty concerning the handover as between Dr Allen and Dr Ramasamy, the lack of clarity as to which doctor was responsible over a critical period, and an apparent misunderstanding on how urgently the phosphate enema was to be administered.

## Dr Ramasamy's review

**169.** Turning back to Child R's medical management on the day, in her subsequent review Dr Phillips noted the next relevant step, which was that the nursing staff on the ward escalated their concerns about Child R to medical staff and that Child R was re-assessed by Dr Ramasamy. Specifically, shortly before 9.30 am Child R's high heart rate, fast breathing and unwell state was brought to the attention of the clinical nurse manager, the Registered Nurse Phillip Vuong (RN Vuong).[102]

**170.** RN Vuong's opinion was that Child R was very unwell and needed to be flown out of Halls Creek for better management and treatment. He had regard to Child R's condition and the weather forecast for the week, and escalated the matter to Dr Ramasamy, for review of Child R.[103]

**171.** Having had the matter escalated to him by the nursing staff, Dr Ramasamy reviewed Child R at 9.30 am. At this point, it is clear that Child R came into his care. Dr Ramasamy was aware of some of Child R's medical history, including that she was prone to recurrent bouts of severe constipation, that she needed regular laxatives and sometime bowel washouts.[104]

**172.** Dr Ramasamy explained that while, as doctor in charge of the Emergency Department, he would not ordinarily manage a patient on the ward, he went to review Child R as he was asked for his help. At this stage, Child R was continuing to vomit, even though she had been administered an antiemetic medication.[105]

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[102] Exhibit 2, tab 30.
[103] Exhibit 1, tab 14.
[104] Exhibit 1, tab 23.
[105] Exhibit 1, tab 23.

**173.** At the time he examined Child R, Dr Ramasamy's understanding was that Dr Allen had already contacted the Broome Paediatrician who was familiar with Child R's history (being Dr Nemba) and that he had advised that she be given enemas, and that transfer to Broome was not required at that stage.[106]

**174.** Upon arrival, Dr Ramasamy found Child R to be distressed and anxious and he felt this was made worse by her anxious family members. He also felt that some family members were unhappy about him reviewing Child R, due to past disagreements regarding his medical treatment of other family members. He sought but was unable to get a clear history from the family about whether Child R had regularly been given her Movicol medications.[107]

**175.** Dr Ramasamy examined Child R and his notes reflect that she had a dry tongue, her capillary refill was between two and three seconds, she was vomiting repeatedly, and her abdomen was grossly distended. Her bowel sounds were scanty, her pulse was 140 beats per minute and her blood pressure was 90/40 mmHg.[108]

**176.** Dr Ramasamy's clinical impression was that Child R was dehydrated, possibly from the repeated vomiting and he decided to insert an intravenous line, give her an immediate fluid bolus and then commence some maintenance fluids, a course that Dr Nair (on his subsequent review of the medical management) considered to be appropriate, in terms of the process. Dr Ramasamy's plan was to assess the impact of the fluid bolus on Child R's dehydration, tachycardia, and general condition before contacting Dr Nemba to suggest and arrange transfer to Broome.[109]

**177.** At this point in time, in Dr Nair's view, given on his subsequent review of the available medical records, an alternative diagnosis besides chronic constipation should have been considered, such as toxic megacolon, intestinal obstruction or a bowel perforation.[110]

**178.** It is noteworthy that on her subsequent review of Child R's medical care and treatment, Dr Phillips felt that a transfer request for Child R (to Broome Hospital) could have been triggered by the nursing escalation process at 9.30 am. I have noted the WA Country Health Service's submission through its lawyer the SSO, to the effect that the clinical picture for Child R did not become clearer until after 11.00 am. Nonetheless, I accept Dr Phillips' view

[106] Ibid.
[107] Exhibit 1, tabs 23 and 24.
[108] Exhibit 1, tab 24.
[109] Exhibit 1, tab 23; Exhibit 2, tab 30; ts 99 to 100; ts 122 to 123.
[110] Exhibit 2, tab 30.

and am satisfied that a transfer request at approximately 9.30 am would have been in Child R's best interests.[111]

**179.** Unfortunately, Dr Ramasamy did not have sufficient information before him, at approximately 9.30 am, to make that telephone call to the Royal Flying Doctor Service. At the material time, the nursing staff were not authorised to make such calls, it needed to be done by a doctor. This is where continuity of care, previously referred to, becomes important.

**180.** Turning back to the administration of the fluid bolus, Dr Ramasamy reported difficulty in getting consent from Child R's family to the IV cannulation and felt that their reluctance to give consent was due in part to their view that this was another episode of severe constipation, and their concern about invasive treatments. He was also of the view that they remained unhappy with him treating Child R, for reason outlined previously. Ultimately, he secured their consent, and IV cannula was inserted, blood tests were taken, and the fluid bolus was commenced at 10.15 am. Those blood tests were subsequently analysed and found to indicate dehydration in a child.[112]

**181.** Specifically, Child R's blood tests were performed using the i-STAT machine, that allows for certain tests results to be promptly generated. Child R's blood test results became available at 10.05 am. However, they were generated by reference to adult ranges and not by reference to ranges that would be applicable to a child. This was how the i-STAT machine operated at the time. The unfortunate outcome, as will be seen below, was that the clinicians were not able to promptly assess Child R's blood test results by reference to the acceptable ranges in a child.

**182.** Through its lawyer the SSO, the WA Country Health Service accepts that an age-related reference range chart was not readily available to assist in interpreting Child R's i-STAT results on 5 January 2017.[113]

**183.** The Department of Health has since produced i-STAT age and gender related biochemistry reference ranges which are addressed under the heading *Improvements*, later in this finding.

**184.** However, at the material time a clinician reviewing the i-STAT results for Child R at 10.05 am would have noted the haemoglobin was slightly high, but that creatinine and potassium were within the normal range. But this

[111] Ibid.
[112] Exhibit 1, tabs 23 and 24.
[113] Exhibit 1, tab 24.

was the reference range for an adult. When the range is reviewed by reference to a child, it would have been seen that creatinine and potassium were high, sodium was low, and in combination they would have quickly suggested dehydration and renal impairment to a reviewing clinician, and care would undoubtedly have been escalated.[114]

**185.** Dr Ramasamy reviewed Child R again and noted that there was no improvement in her condition despite the fluid bolus having commenced. With the benefit of hindsight Dr Ramasamy testified that he should have called the paediatrician in Broome (Dr Nemba) at the time he started the fluid bolus (approximately 10.15 am), rather than waiting to assess, to a degree, the impact of the fluid bolus.[115]

**186.** It is now known that i-STAT blood results for Child R at 10.05 am revealed significant dehydration with likely secondary acute renal impairment. At the inquest Dr Phillips testified that Child R had "*acute renal failure and acute renal impairment*" at 10.00 am. In Dr Phillips' experience, you do not get renal impairment by not having fluids for a few hours: "*You get that from days of not having enough fluid, for whatever reason, being absorbed by your body*".[116]

**187.** From this result Dr Phillips extrapolated that Child R had severe dehydration on presentation to Halls Creek Hospital. I am satisfied that the severity of Child R's dehydration was not recognised because an age-related reference range chart was not readily available to assist in the interpretation of the i-STAT results.[117]

**188.** Dr Phillips explained that in retrospect, the fluid bolus given by Dr Ramasamy at 10.15 am would not have been expected to fully remediate Child R's hydration status. With the benefit of hindsight (and now with the availability of an age-related reference range chart) through his lawyer, Dr Ramasamy informs the court that he accepts that the 10.05 am i-STAT results suggested that Child R might have benefitted from a faster administration of the fluid bolus.[118]

**189.** At the inquest Dr Phillips drew attention to Dr Nair's opinion and said that at this point a "*resus dose*" of IV fluids would have been the right treatment. Specifically, the fluid bolus that was given to Child R over an hour and a

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[114] Ibid.
[115] Exhibit 1 tab 23; Exhibit 2, tab 30; ts 113.
[116] ts 279.
[117] Ibid.
[118] Exhibit 1, tabs 23 and 24; Exhibit 2, tab 30.

quarter should have been given over 15 minutes. I accept that opinion but note that Dr Ramasamy did not have the correct reference ranges available to him, that would otherwise have shown him the severity of Child R's dehydration.[119]

**190.** Dr Phillips also suggested that repeating the i-STAT blood tests within two hours of commencing the fluids would have provided objective evidence of whether or not the fluid volumes were correcting the dehydration.[120]

**191.** Dr Phillips reviewed Child R's medical record and her impression was that it did not reflect that the clinical team appreciated how unwell Child R was becoming. Dr Phillip's view, that I accept, is that Halls Creek Hospital does not have the ability to manage acutely unwell children, and it did not have capacity for this in 2017.[121]

**192.** Nonetheless, Dr Ramasamy acted promptly on the basis of the information that he did have. He reviewed Child R again after the fluid bolus had commenced and noted no improvement in Child R's condition. Dr Ramasamy decided not to await the completion of the administration of the fluid bolus (which occurred at 11.30 am) and proceeded to contact Dr Nemba in Broome at approximately 11.00 am. The details are outlined immediately below.

## Dr Ramasamy's consultations with Dr Nemba

**193.** At approximately 11.00 am Dr Ramasamy contacted Dr Nemba (the Consultant Paediatrician at Broome Hospital) by telephone and requested that Child R be transferred to Broome Hospital. This was the same doctor that Dr Allen had called at 8.30 am that morning.[122]

**194.** Dr Ramasamy recalled that he told Dr Nemba about his concern about Child R having a bowel obstruction. However, Dr Nemba was not certain that this concern was specifically mentioned by Dr Ramasamy to him in this 11.00 am telephone conversation.[123]

**195.** In any event the conversation became focussed upon compliance with Dr Nemba's earlier advice to Dr Allen, given at approximately 8.30 am that

[119] Exhibit 1, tab 24; Exhibit 2, tab 30.
[120] Ibid.
[121] Exhibit 2, tab 30.
[122] Exhibit 1, tab 23.
[123] Exhibit 1, tab 23; Exhibit 2, tab 29.

morning, for Child R to be given a phosphate enema, with a call back if it did not work. It had not yet been given, and Dr Nemba wanted it given. In Dr Nemba's view, if the phosphate enema did not provide relief from what was believed to be faecal impaction, it would indicate Child R had a bowel obstruction and make the clinical picture clearer. Dr Nemba wanted a call back after the phosphate enema was administered.[124]

**196.** During that 11.00 am telephone conversation, the details concerning Child R's condition, including ongoing vomiting, dehydration, scanty bowel sounds, borderline low blood pressure and elevated heart rate were not conveyed to Dr Nemba by Dr Ramasamy. This is likely due to the focus of that conversation being on Dr Nemba wanting compliance his earlier advice.[125]

**197.** At the inquest Dr Ramasay described the telephone conversation with Dr Nemba as "*tense*" and interrupted by Dr Nemba's focus on whether the phosphate enema had been given. Dr Ramasamy felt that with the benefit of hindsight, he should have persisted in putting his view across to Dr Nemba, which would have included his belief that Child R had a bowel obstruction, and the information about her observations.[126]

**198.** Dr Nemba subsequently informed the court that if, at the 11.00 am telephone conversation, he had been aware of the full context of Child R's condition, he would have recommended then that her treatment be escalated for potential bowel obstruction (as happened during his later telephone conversation with Dr Allen at 11.40 am).[127]

**199.** At the inquest, and also with the benefit of hindsight, Dr Nemba was asked whether he would have done anything differently. Dr Nemba felt that he could have listened more to the medical practitioners, which might have initiated advice from him for the treatment for bowel obstruction at the earlier stage. This was an appropriate insight on his part.[128]

**200.** Through her lawyer the ALS, Child R's mother submits that this telephone conversation between Dr Ramasamy and Dr Nemba was another missed opportunity to have Child R admitted to Broome Hospital as soon as possible.

[124] Exhibit 1, tab 23; Exhibit 2, tab 29; TS 168.
[125] Ibid.
[126] ts 115 to 116.
[127] Exhibit 2, tab 29.
[128] ts 173.

**201.** I accept that submission and note that, as referred to earlier in this finding under the heading *Delay*, through its lawyer the SSO, the WA Country Health Service accepts that the delayed administration of the phosphate enema delayed Child R's management at 11.00 am. Specifically, the delay impacted upon the interaction between Dr Nemba and Dr Ramasamy, as Dr Nemba focussed upon the compliance with the advice regarding the phosphate enema that he had previously given during his first telephone conversation with Dr Allen at approximately 8.30 am that morning.

**202.** If the phosphate enema had been administrated in accordance with Dr Nemba's advice, shortly after the 8.30 am telephone conversation, and if it were to have been reported to Dr Nemba that it did not have the desired result, it is likely that Dr Nemba would have accepted Child R for transfer to Broome Hospital immediately upon being informed. This is likely to have been shortly after 8.30 am, perhaps by 9.30 am, but in any case well before the 11.00 am telephone conversation with Dr Ramasamy.

**203.** Turning back to the treatment of Child R on that day, following his conversation with Dr Nemba, Dr Ramasamy handed the care of Child R back to Dr Allen. Both Dr Ramasamy and Dr Allen referred to Child R's family members shouting at this stage and being unhappy that Child R was being treated by Dr Ramasamy. Dr Allen reported that the Aboriginal Liaison Officer had called her back to the ward due to the expressed unhappiness of the family. Dr Allen spoke with the family to hear their concerns. She found the shouting to be confusing and confronting. It appears the family may have been unhappy or worried about the insertion of the IV cannulation. There was also discussion about Child R having not been given her Movicol at home for approximately six weeks. [129]

**204.** When Dr Ramasamy handed the care of Child R back to Dr Allen, at 11.00 am, he said the following to Dr Allen:

(a) He relayed the outcome of his telephone conversation with Dr Nemba, for the phosphate enema to be administered;

(b) He said he thought Child R had an acute bowel obstruction;

(c) He advised of the need for Child R to be referred to the paediatrician at the Broome Hospital; and

[129] Exhibit 1, tabs 13 and 23; ts 19 to 20.

(d) He explained that he felt his presence was obviously and seriously escalating the family's agitation.[130]

**205.** Arrangements were made to have the phosphate enema urgently administered to Child R. It was administered at approximately 11.30 am, with the result of a small amount of soft bowel action. Within the context of Child R's condition, it was an unsatisfactory outcome.[131]

## Decision to transfer Child R to Broome Regional Hospital

**206.** When Dr Allen reviewed Child R for a second time, the phosphate enema had been administered. Child R was not improved, and Dr Allen looked for a source of sepsis. Dr Allen agreed with Dr Ramasamy, forming the view that Child R had a bowel obstruction, and that Halls Creek Hospital did not have the resources to look after her. Dr Allen noted that Child R's abdomen was more distended.[132]

**207.** At approximately 11.40 am Dr Allen contacted Dr Nemba for the second time that day (this being the third call Dr Nemba had received from Child R's doctors at Halls Creek that day), and this telephone call resulted in Child R being accepted for transfer to Broome Hospital. Dr Allen informed Dr Nemba that Child R's condition had deteriorated, that her blood results indicated dehydration and that only a minimal amount of faecal material had passed after the phosphate enema. It was understood now that Child R most likely had a bowel obstruction.[133]

**208.** Dr Nemba's advice was to escalate treatment in view of probable dehydration, which involved giving a second intravenous fluid bolus, and then to continue IV fluids at a rate above maintenance levels. Dr Nemba also advised Dr Allen to insert a nasogastric tube to achieve drainage of stomach contents and to organise the transfer to Broome Hospital with the Royal Flying Doctor Service. He proceeded to make the necessary arrangements to receive Child R at Broome Hospital.[134]

**209.** Dr Allen was very concerned about Child R's condition. Unfortunately, over this period she was also responsible for undertaking another GP Outpatient Clinic consult, and she was trying to discharge her patients on the

[130] Exhibit 1, tab 23; ts 20.
[131] Exhibit 1, tab 24.
[132] ts 20.
[133] Exhibit 1 tabs 13and 20; Exhibit 2, tabs 29 and 30; ts 20 to 23.
[134] Exhibit 2, tabs 29 and 30; ts 142 to 143.

ward, as well as commencing transport arrangements in connection with Child R's transfer to Broome Hospital. She reported that she found the telephone call with Dr Nemba difficult in part because some family members were yelling and she herself was distressed. However, she felt that Dr Nemba reassured her, in that she was doing the right thing. She was less anxious after this telephone call.[135]

**210.** Turning back to Child R's treatment, a nasogastric tube was inserted on Dr Nemba's advice. Nasogastric aspiration was undertaken and what appeared to be faeculent fluid was noted. This was consistent with their working diagnosis of a mechanical bowel obstruction. Child R was very unwell at this stage, with tachycardia and tachypnoea.[136]

**211.** In the experience of the independent expert senior Consultant Paediatrician Dr Nair, the presence of faeculant vomiting and gross abdominal distention requires urgent consideration of a diagnosis of acute bowel obstruction. Dr Nair described this as a medical emergency that, without resolution, may progress to intestinal necrosis, perforation and sepsis, multi organ failure and death.[137]

**212.** After Dr Allen's second telephone conversation with Dr Nemba, Child R's condition continued to deteriorate at an escalating pace, a development that Dr Allen had not anticipated in light of her reassuring conversation with Dr Nemba. From Dr Allen's perspective, Dr Nemba did not convey "*a sense of urgency*" and she had no prior experience in managing a child with this condition.[138]

**213.** I have considered this aspect. Taking account of the fact that by this stage, Dr Nemba and Dr Allen were both of the view that Child R likely had a bowel obstruction, a sense of urgency for the placement of a telephone call to the Royal Flying Doctor Service should have been self-evident.

**214.** However, Child R's on-site treatment was also urgent, and immediate steps were taken to stabilise her in accordance with Dr Nemba's advice. Unfortunately, there were difficulties with the insertion of the nasogastric tube. Child R was resistant and later on she pulled it out. Assistance was sought from other clinicians to manage Child R's treatment.[139]

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[135] Exhibit 1, tab 13; ts 22.
[136] Exhibit 1, tabs 13, 20 and 24; Exhibit 2, tabs 29 and 30; ts 22 to 23.
[137] Exhibit 1, tab 20.
[138] Exhibit 1, tab 13; ts 60 to 62.
[139] Exhibit 1, tabs 13 and 24.

**215.** Meanwhile Dr Allen was also liaising with the family to obtain their consent to have Child R transferred to Broome. After some discussion that she said "*took time*" consent was obtained. Dr Allen continued to experience difficulty in her discussions with the family and at one stage had formed the impression that some family members were more focussed on getting to Broome themselves if Child R was to be transferred there.[140]

**216.** Through her lawyer, Dr Allen cited a number of factors by way of explanation as to why time passed, and it took her approximately one hour to call the Royal Flying Doctor Service (after her 11.30 am telephone conversation with Dr Nemba). She cited her ward duties, her GP Outpatient Clinic duties, as well as the difficult process of inserting the nasogastric tube, as some of the reasons as to why she was unable to immediately call the Royal Flying Doctor Service.[141]

**217.** Another factor potentially contributing to the passage of time before a telephone call was made was that in 2017, the process was for the doctor (and not a nurse) to make the call to the Royal Flying Doctor Service. Dr Allen therefore had to make that telephone call herself.[142]

**218.** The events surrounding Dr Allen's contact with Royal Flying Doctor Service are outlined immediately below, within the context of the deterioration of Child R's clinical condition.

## CHILD R'S CONDITION DETERIORATES

**219.** Child R continued to develop progressively increasing abdominal distension and continued vomiting during the morning while she was on the ward at Halls Creek Hospital. Dr Allen called the Royal Flying Doctor Service twice, once at approximately 12.30 pm to outline the situation and book the transfer, and once shortly after 3.00 pm when Child R experienced a further and marked deterioration.

**220.** The Royal Flying Doctor Service, with Dr Kabbabe on board, left Derby at approximately 2.00 pm to go directly to Balgo to collect another patient, before arriving at Halls Creek at approximately 5.00 pm to collect Child R. Both patients were for transfer to Broome Hospital.[143]

[140] Exhibit 1, tab 13; ts 22 to 24.
[141] Ibid.
[142] ts 23 to 24.
[143] Exhibit 1, tabs 17 and 20.

**221.** The details appear below.

## First call to RFDS

**222.** At approximately 12.30 pm Dr Allen called the Royal Flying Doctor Service and was put through to Dr Benjamin Kabbabe (Dr Kabbabe) the on duty medical officer attached to their Derby base. She conveyed certain information to him as follows:

**(a)** That Child R had congenital abnormalities including a recto-vaginal fistula from birth and chronic constipation;

**(b)** That recently she had been refusing her Movicol;

**(c)** That she had come in to Halls Creek Hospital with abdominal distention (not tender but very distended) and vomiting. There was one vomit as from when she first arrived, and approximately six further vomits since then, with faeculent vomiting noted;

**(d)** That she was probably significantly dehydrated with hyperkalaemia (potassium 5.1); an outline was given of the treatment for her fluid maintenance (details were given of the fluid bolus followed by fluid maintenance) and the treatment for her distended abdomen (details were given of the nasogastric tube);

**(e)** That she had been having "*good urine output*" until she came in and that the clinicians had maintained that;

**(f)** That she was tachycardic (heart rate sitting at around 150 beats per minute since presentation, but had recently gone up to 163 beats per minute);

**(g)** That she was afebrile, and her glucose was not elevated;

**(h)** That two rectal enemas had been given with minimal effect (microlax and phosphate enemas); and

**(i)** That she had been accepted for transfer to Broome Hospital by Dr Nemba.[144]

[144] Exhibit 1, tabs 17, 24 and 26; ts 26.

**223.** During Dr Allen's telephone discussion with Dr Kabbabe, Dr Allen posited that the family's agitation was contributing to Child R's heart rate going up, and a request was made by or on behalf of Dr Allen for Child R's family members (other than her mother) to leave the room.[145]

**224.** Dr Kabbabe advised Dr Allen to administer another IV fluid bolus and he initiated the arrangements for the Royal Flying Doctor Service to collect Child R from Halls Creek Hospital and convey her to Broome Hospital. On the pre-flight assessment he recorded a principal diagnosis of bowel obstruction. He also recorded that a doctor would be required in flight due to Child R's ongoing and worsening tachycardia and the need for further IV fluid titration and iStat analysis.[146]

**225.** Dr Kabbabe allocated a Priority 2 rating to the evacuation and advised Dr Allen that they would try and get there within four hours. He was satisfied that the management plan put together at Halls Creek Hospital was safe and competent, and that Child R could be safely transferred later that day for management at Broome Hospital.[147]

**226.** A Priority 2 rating is for urgent medical transfers, requiring crew to depart within 4.5 hours of a transfer request. When this urgency rating was subsequently reviewed by the Executive General Manager for Clinical at the Royal Flying Doctor Service (Western Operations) she considered it to be an appropriate determination having regard to the following factors:

- **(a)** Child R was in a hospital setting receiving appropriate treatment (including IV fluids and nasogastric tube); and

- **(b)** She was for transfer to Broome under the care of an experienced paediatrician, as opposed to, for example, transfer to ICU at Perth or Darwin for urgent surgical intervention).[148]

**227.** In her subsequent review of this aspect, Dr Phillips, Regional Director of Medical Services with WA Country Health Service, considered that the information provided to Dr Kabbabe by Dr Allen about Child R having maintained "*good urine output*" was likely to have falsely reassured him as to Child R's condition and the impact of treatments at the time. Dr Phillips

[145] Exhibit 1, tab 17.
[146] Exhibit 1, tabs 17 and 26.
[147] Exhibit 1, tab 17.
[148] Exhibit 1, tab 26.

drew attention to the fact that at the time of this telephone call, the fluid balance chart revealed no urine output having been recorded. In fact, Child R was dehydrated and tachycardic and it is now known that she had evidence of abnormal renal function.[149]

**228.** It would appear that Dr Allen may have believed that they had maintained good urine output at Halls Creek Hospital, and that the situation may have become confused by the outcomes of some of the enemas given to Child R. Further, as noted earlier in this finding, the lack of an age-related reference range chart meant that the severity of Child R's dehydration was not recognised by the clinicians.

**229.** Therefore on the basis of the information provided to him, I am satisfied that the Priority 2 rating given by Dr Kabbabe was reasonable in the circumstances.

**230.** Dr Allen proceeded to prepare a referral letter to Broome Hospital. Meanwhile, Dr Kabbabe made the evacuation arrangements with the Royal Flying Doctor's Coordination Centre. He was tasked to depart a little over an hour from the original transfer request for Child R. However, before departing, he was also tasked to first collect a second patient from Balgo, and take this patient, together with Child R to Broome Hospital.[150]

**231.** Dr Kabbabe did not have a concern about the impact of this additional task on Child R, given the location of both patients, and what was known to him about their respective conditions.[151]

**232.** Dr Kabbabe did not anticipate the marked deterioration in Child R's condition, that would subsequently occur that afternoon (and at this stage could not have anticipated it). The deterioration in Child R's condition is addressed below.

## Further deterioration

**233.** Dr Allen reported to the coroner that at about 1.00 pm Child R's condition deteriorated further. She noted that Child R's pulse and respiratory rate were increasing. Records reflect that at 1.45 pm Child R was commenced on maintenance fluids, after the next recommended IV fluid bolus was

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[149] Exhibit 1, tab 24; Exhibit 2, tab 30.
[150] Exhibit 1, tabs 17 and 26.
[151] Exhibit 1, tab 17.

given. At this stage Child R was vomiting brown stained fluid and she had also pulled out her nasogastric tube.[152]

**234.** Between 1.30 pm and 3.00 pm Dr Allen requested the assistance of another doctor who had just commenced his shift at the hospital. This doctor inserted an intravenous cannula and attempted unsuccessfully to re-insert the nasogastric tube (and there had been numerous unsuccessful attempts made before he attempted to insert it). The aim was to decompress Child R's abdomen. It was noted that the swelling of her abdomen was making it increasingly difficult for her to breathe.[153]

**235.** As Child R's condition deteriorated, she was moved, first to another bed in the ward where she could be more closely monitored, and then at approximately 3.30 pm to a resuscitation bay in the Emergency Department of Halls Creek Hospital, with a view to making a further attempt to re-insert the nasogastric tube, and to insert another IV line. She was tachypnoeic and tachycardic.[154]

## Second call to RFDS

**236.** In the meantime, shortly after 3.00 pm, Dr Allen made a second call to the Royal Flying Doctor Service to advise of the deterioration in Child R's condition. Dr Allen spoke with a doctor who was the Clinical Co-ordinator at Jandakot on this occasion. She reported some of the history and advised that Child R's heart rate was 166 beats per minute and that she had a respiratory rate of between 35 and 40 breaths per minute.

**237.** On this occasion in her telephone conversation Dr Allen advised the Clinical Co-ordinator that Child R had "*excellent urine output*" until 9.00 am that morning, but that since then she was not aware of the output, because of the enemas. Noting, as mentioned previously, that the fluid balance chart does not record any urine output, I infer that this information was given by Dr Allen from her own knowledge. Through her lawyer Dr Allen advises that she did not know what else they could do at Halls Creek Hospital while awaiting the transfer.[155]

**238.** In this second telephone call with the Royal Flying Doctor Service's Clinical Co-ordinator Dr Allen advised of the difficulty with the re-insertion of the

[152] Exhibit 1, tabs 13 and 24.
[153] Exhibit 1, tabs 13, 16, 20 and 24.
[154] Exhibit 1, tabs 16 and 24.
[155] Exhibit 1, tab 17.

nasogastric tube, and of Child R's very understandable agitation. Her abdomen was more distended and without the nasogastric tube, they were not able to decompress it, resulting in her increased work of breathing. In discussion with the Royal Flying Doctor Service doctor, it was agreed that Dr Allen would arrange for the administration of an appropriate dose of ketamine to calm Child R, to assist with the re-insertion of the nasogastric tube.[156]

**239.** Child R was administered the ketamine shortly afterwards but further attempts to reinsert the nasogastric tube remained unsuccessful. Some nine attempts were made overall, which must have been frightening for Child R. She was screaming, and her family were highly agitated. There was comment at the inquest about whether an adult sized nasogastric tube was being used, as opposed to a smaller one. However, the independent expert Dr Nair had regard to Child R's age, and the function of the tube in her case, and considered there was nothing inappropriate about its size. I accept that view.[157]

**240.** Between 3.50 and 4.00 pm, antibiotics were administered as Child R had developed a fever. Blood tests done at 3.10 pm showed that Child R had become severely compromised, with indications of renal dysfunction and markedly impaired tissue perfusion. Her condition worsened to a critical point, where she began to experience multi-organ dysfunction.[158]

**241.** Dr Allen attempted to contact the Emergency Physician through the Emergency Telehealth service but was unable to establish contact with the relevant physician. She then promptly contacted the Paediatricians at Broome Hospital and in discussion it was determined that Child R would need to go to Royal Darwin Hospital as it had an ICU. Child R would need to be intubated and ventilated and preparations for this were commenced at Halls Creek Hospital.[159]

## RFDS arrival and resuscitation

**242.** The Royal Flying Doctor Service with Dr Kabbabe on board landed at Halls Creek at approximately 5.00 pm. As the flight was taxiing on the runway, Dr Kabbabe received a telephone call from their Clinical Co-ordinator who

[156] Exhibit 1, tabs 13, 16, 17, 20, 24 and 26; ts 254; ts 271 to 272.
[157] Exhibit 1, tabs 13, 16.
[158] Ibid.
[159] Exhibit 1, tabs 13, 20 and 24.

advised of Child R's marked deterioration, her respiratory compromise, and the unsuccessful attempts to insert the nasogastric tube at Halls Creek.[160]

**243.** Dr Kabbabe arrived at the resuscitation room of Halls Creek Hospital at approximately 5.20 pm and Dr Allen informed him that they were preparing to intubate Child R on the advice of the Broome Paediatricians. Dr Allen reports that at this stage, she handed over care of Child R to the Royal Flying Doctor Service.[161]

**244.** Dr Kabbabe observed that Child R was moribund and about to arrest. Her blood pressure was critically low, and she had shallow breathing. There were no recordable oxygen levels. Her Glasgow Coma Scale was 6. Dr Kabbabe immediately intubated Child R and noted that ventilation was difficult due to the abdominal distension. He inserted a nasogastric tube to decompress the abdominal distension. Medications including noradrenalin were commenced to try and improve her blood pressure, and medications were also given for sedation. There was no urine output and a further two boluses of normal saline were given.[162]

**245.** At approximately 6.00 pm Dr Kabbabe discussed the case with a Consultant from the Royal Darwin Hospital ICU, who advised him to continue with the resuscitation, but felt that Child R would probably not survive. The resuscitative efforts continued, with a number of doctors from Halls Creek Hospital assisting Dr Kabbabe, including Dr Allen and Dr Ramasamy. Child R's condition was dire, and all efforts were being made to stabilise her.[163]

**246.** At approximately 7.00 pm Dr Kabbabe decided to transfer Child R to the ambulance, to try and get her flown to Royal Darwin Hospital. Child R was loaded onto the ambulance at 7.20 pm. As this was being done, Dr Kabbabe noted an impending cardiac arrest, and Child R was immediately returned to the resuscitation room, by 7.25 pm.[164]

**247.** Immediate steps were taken to commence CPR, with ventilation being performed with an air viva bag. Five cycles of CPR were completed and during three of the cycles the defibrillator delivered shocks for ventricular

[160] Exhibit 1, tab 17.
[161] Exhibit 1, tabs 13 and 17; ts 28.
[162] Exhibit 1, tabs 13, 17, 20 and 24.
[163] Exhibit 1, tabs 17, 20 and 24.
[164] Ibid.

tachycardia. Resuscitation efforts continued but Child R was unable to be revived. Child R was pronounced dead at 7.45 pm on 5 January 2017.[165]

**248.** The independent expert Dr Nair subsequently reviewed the life-saving measures. In his view the team of the Royal Flying Doctor Service did everything possible to try and save Child R. Dr Nair agreed with the view expressed by the Consultant from the Royal Darwin Hospital ICU, that Child R would not likely survive by that stage, but that it was appropriate to continue to try and persist with resuscitative measures.[166]

**249.** In Dr Nair's opinion the resuscitative measures were duly undertaken by Dr Kabbabe as recommended by the Consultant from the Royal Darwin Hospital ICU. Dr Nair had no concerns in regard to the overall management undertaken by the Royal Flying Doctor Service Team. He described those resuscitative efforts as extensive and very thorough. I accept his opinion.[167]

## CAUSE AND MANNER OF DEATH

**250.** On 13 January 2017 the forensic pathologist Dr G.A. Cadden (Dr Cadden) made a post mortem examination at the State Mortuary on the body of Child R. Upon examination a very marked distension of the large bowel was present. The distal large bowel had a markedly dilated appearance (megacolon) and within this segment of the bowel, impacted faeces were present in the lower aspect, within an area of tightly bound adhesions. Small areas of tissue death (infarction) were also evident in respect to the left kidney.[168]

**251.** On that date Dr Cadden formed the opinion that the cause of death was acute bowel obstruction secondary to impacted megacolon. He had noted that it was within the setting of an abnormally located anal opening.[169]

**252.** Toxicological analysis became available in April 2017 and was reviewed by Dr Cadden in May 2017. The various medications identified were in keeping with Child R's period of hospitalisation and had no bearing upon Dr Cadden's opinion on Child R's cause of death. Dr Cadden's opinion remained the same.[170]

[165] Exhibit 1, tabs 17, 20 and 24.

[166] Exhibit 1, tab 20.
[167] Ibid.
[168] Exhibit 1, tab 5.
[169] Exhibit 1, tab 5.
[170] Exhibit 1, tabs 5 and 6.

**253.** After the close of evidence at the inquest, through their lawyer the SSO, the WA Country Health Service drew the court's attention to blood culture results for Child R that had not been included within the original medical records for Child R. They were results of blood tests requested by Dr Allen on 5 January 2017, collected at 4.00 pm on that date and reported on 12 January 2017. The reported blood culture results raised the question of whether Child R had sepsis, due to a positive result for E. coli.[171]

**254.** It usually takes about 72 hours for the Broome PathWest laboratory to process blood culture samples, and therefore the results would not have been available to Dr Allen or Dr Nemba on 5 January 2017. Once reported, the blood culture results became available on the departmental electronic pathology and imaging results system (iCM), on 10 or 12 January 2017.[172]

**255.** The process was and still is, for electronic blood culture results to be printed and signed by the doctor who reviewed them, and then placed on the physical medical records file. On this occasion, the blood culture results were not on Child R's medical file. WA Country Health Service has posited that they may not have been placed on Child R's medical file because the file was being held securely after her death, though notes that this is speculation. There is insufficient information before me, for me to reach a conclusion as to why the blood culture results were not on Child R's hard copy medical file.[173]

**256.** Consultant Forensic Pathologist and Head of Department Dr J. White (Dr White) reviewed the relevant records at the State Mortuary (including the more recently received blood culture results) and formed the view that it was most likely that Dr Cadden had not reviewed these blood culture results when he formed his opinion on the cause of death.[174]

**257.** Dr White's view, when she initially reviewed the blood culture results, was that they do not really affect the opinion given on the cause of death, because sepsis is seen as a complication of a bowel obstruction and is part of the underlying mechanisms of the cause of death, along with multiple organ failure and death.[175]

**258.** Following the inquest (and after the view provided by Dr White as outlined immediately above) through their lawyer the SSO, the WA Country Health

[171] Exhibit 1, tab 5.
[172] Ibid.
[173] Ibid.
[174] Ibid.
[175] Exhibit 1, tab 5.

Service submitted a report to the court from Dr Levitt, Consultant Medical Director with the WA Country Health Service, colorectal surgeon. The report was taken into evidence and distributed to the parties to the inquest.[176]

**259.** Dr Levitt's report was prepared due to the subsequent availability of the blood culture results that showed the growth of E. coli. This was a matter that Dr Levitt considered highly likely to be clinically significant within the context of the clinical issues that contributed to Child R's death. Dr Levitt considered E. coli sepsis to represent the likely primary cause of death. In his opinion, while there could be a urinary origin for the E. coli, given Child R's clinical presentation with abdominal pain and faecal impaction, it is at least in keeping with a gastrointestinal origin. A possibility would be bacterial translocation through an attenuated intestinal wall.[177]

**260.** Dr Levitt questioned the observations of the clinical staff at Halls Creek about there being "*faeculant vomiting*" in light of the subsequent post mortem findings of the presence of only mild distension of only the distal small intestine, in combination with the stomach being empty. Child R's medical notes had referred to her "*vomiting brown stained fluid*."[178]

**261.** Dr Levitt considered that the colonic and rectal findings at post mortem examination were consistent with chronic colorectal dilatation. He questioned the forensic pathologist's conclusion about Child R having an acute mechanical large intestinal obstruction (although Dr Cadden did not refer to it as being "*mechanical*"). Dr Levitt has attributed Child R's tachycardia and early renal failure to the E. coli sepsis, probably aggravated by dehydration.[179]

**262.** The differences between the opinions of Dr Cadden and Dr Levitt regarding the likely cause of Child R's death (or the contributing factors) arise in substantial part due to the subsequently received blood culture results. A copy of Dr Levitt's report was provided to Dr White for review and advice, as to the cause of Child R's death. Dr White provided a report to the coroner.[180]

**263.** In Dr White's view, Dr Cadden was referring only to the faeces as the obstruction, and he had not stated that the obstruction was "*mechanical*". She has explained that Child R's bowel was over distended and unable to be

[176] Exhibit 2, tab 31.
[177] Ibid.
[178] Exhibit 1, tab 24; Exhibit 2, tab 31.
[179] Exhibit 2, tab 31.
[180] Exhibit 1, tab 5; Exhibit 2, tab 31.

emptied, becoming acutely blocked by the excessively large amount of hard faecal matter, with the result that Dr Cadden used the term "*obstruction*". She does not think that term has been used incorrectly.[181]

**264.** Dr White has had regard to Dr Cadden's gross findings at post mortem of faecal impaction and dilatation of the large bowel and considers that, in conjunction with the clinical circumstances provided at the time, these are consistent with the E. coli sepsis originating within the intestinal tract:

> "*The large amount of hard faecal matter, likely to have built up over time and with repeated episodes has led to gross distension of the colon, with flattening and eventual injury on this occasion to the mucosal lining, thereby leading to E. coli sepsis (mucosal bacterial translocation – as per Mr Levitt's letter)*."[182]

**265.** Dr White's report to the coroner was distributed to the parties to the inquest, with an opportunity provided for further comment and/or submission, before I make my finding on the cause of Child R's death. The parties did not make any comment or submission on the matter of the cause of Child R's death.

**266.** Having regard to Dr Cadden's post mortem examination and opinion on cause of death, the subsequently received blood culture results and Dr Levitt's review, in her report to the coroner Dr White has proffered an updated opinion on the cause of Child R's death. I accept and adopt Dr White's updated opinion on the cause of Child R's death. **I find that Child R's cause of death was complications of E. coli sepsis in association with intestinal obstruction due to faecal impaction of megacolon in a child with anorectal anomalies (operated).**

**267.** Child R had developed severe constipation from around 2010 and she had presented multiple times to Halls Creek Hospital Emergency Department with abdominal pain and constipation. She had developed episodes of faecal impaction in the past, necessitating admission to hospital and bowl washouts. In order to manage her constipation, it was important for her to take her daily laxatives.

**268.** Child R's chronic constipation and the complications that followed (including the faecal impaction and mucosal bacterial translocation) arose from her congenital abnormality, specifically an imperforate anus with a

[181] Exhibit 1, tab 5.
[182] Ibid.

rectovaginal fistula, which was surgically repaired. Further complex anal cutback surgery was planned at Princess Margaret Hospital, but the family elected to wait. As outlined previously in this finding, Dr Nair opined that this approach was not completely unreasonable. I make no criticism of the decision to wait, and there is no evidence that the further surgery would have alleviated her chronic constipation. **I find that the manner of Child R's death was by way of natural causes.**

## COMMENTS

### Availability of culturally responsive health service

**269.** There were a number of potential misunderstandings as between Child R’s family, and the Halls Creek Hospital clinicians, that may have adversely impacted upon Child R’s care and treatment. At the inquest the question arose as to whether the misunderstandings might have been better resolved if an Aboriginal Liaison Officer and/or Aboriginal healthcare worker, had been available to take an active part in discussions between the clinicians and Child R’s mother. Self-evidently, this officer’s involvement in such discussions would be at the election of the family.

**270.** For the reasons outlined below, I am satisfied that an Aboriginal Liaison Officer was available at Halls Creek Hospital, that this officer did engage with the clinicians and also had some involvement in discussions with some members of Child R’s family. However, it appears that this officer may not have been directly involved in the conversations between Child R’s mother and the clinicians concerning her care and treatment. Through her lawyer the ALS, Child R’s mother submits this officer’s direct involvement would have assisted her.

**271.** At the material time, there was one Aboriginal Liaison Officer appointed at Halls Creek Hospital. That officer’s duties included travelling into the community and transporting patients to and from hospital appointments, delivering medications, locating patients for their appointments, engaging with people in the community and liaising with clinical staff at Halls Creek Hospital, to assist Aboriginal patients and their families.[183]

**272.** Dr Ramasamy had been working at Halls Creek Hospital in a locum capacity for three months each year, for some nine years. He had had some significant experience with the type of assistance that is able to be given by the Aboriginal Liaison Officer. Dr Ramasamy described his interactions

[183] ts 290.

with the Aboriginal Liaison Officer as a positive experience when they were able to occur. In his experience however, the Aboriginal Liaison Officer was often away in the community, collecting patients.[184]

**273.** In January 2017, given the roles and responsibilities, the one Aboriginal Liaison Officer was not able to be on site at the hospital all the time, and there was no alternative such officer to assist the doctors in engaging with Aboriginal patients.[185]

**274.** At the inquest Dr Nemba reiterated the importance of the Aboriginal Liaison Officer or Aboriginal healthcare worker: "*Aboriginal health workers are very, very important mainly because .... they know the culture, they know the language and they know the people that we're dealing with .... We don't really know what's going on .... We only see them when they come into the hospital*."[186]

**275.** Through its lawyer the SSO, the WA Country Service draws my attention to Dr Allen's evidence about instances on 5 January 2017 when the Aboriginal Liaison Officer interacted with her in connection with Child R. WA Country Health Service submits that the fact that this one officer was not available to assist with communications at all times on that day is essentially to be assessed by reference to the standard of care expected of a hospital in a regional or remote area.

**276.** I have no criticism whatsoever of the one Aboriginal Liaison Officer who interacted to endeavour to assist with the communications on that day. However, the structure of this one person's role, and their overall duties, both within and external to the Halls Creek Hospital site, were not necessarily conducive to the provision, overall, of a culturally safe service.

**277.** At the material time, the Aboriginal Liaison Officer at Halls Creek Hospital was rostered to regular working hours from 7.30 am to 4.00 pm, 76 hours per fortnight. There was no Aboriginal Liaison Officer available to assist with communication when Child R first attended Halls Creek Hospital at 6.55 am on 5 January 2017.

**278.** The misunderstandings commenced at an early stage. In connection with the early interactions, followed by Dr Allen's interactions, they centred upon

[184] ts 107 to 108.
[185] Ibid.
[186] Ts 161.

misunderstandings as to whether Child R's mother was worried about her condition, and the degree to which she (and/or her family) was worried.

**279.** It is, or ought to be, known that persons of different cultures are likely express their worries or concerns in different ways. For this reason, a culturally safe environment can assist in understanding whether a carer is worried about their child. It is important for a clinician to know this.

**280.** The following interactions (some of which are referred to previously in this finding and summarised here) could have been improved if a culturally safe environment was better resourced, and therefore more readily available:

**(a)** The second nurse who saw Child R at 7.15 am on 5 January 2017 recorded in the medical notes that: *"Mother is not very keen to give full history of her child*."[187]

**(b)** Dr Allen reported being "*confused*" at the outset because: "*Child R seemed very unwell, but her mother did not seem worried*"[188]

**(c)** When Dr Allen first called Dr Nemba at approximately 8.30 am, she felt that she did not have the consent of Child R's mother to transfer Child R to Broome Hospital and testified that the mother was "*very clear*" that she did not want this transfer.[189]

**(d)** Later when the prospect of transferring Child R to Broome was being discussed, Dr Allen reported that the family appeared to be more concerned about other issues including how to get everyone to Broome, and again felt the family were not directly concerned about Child R.[190]

**281.** If these issues are not addressed at an early stage, the potential for misunderstandings escalates, and that is what happened on that day.

**282.** The following interactions concerning Dr Ramasamy (some of which are referred to previously in this finding and summarised here) could have been improved if a culturally safe environment was better resourced, and therefore more readily available:

[187] Exhibit 1, tab 24.
[188] Exhibit 1, tab 13.
[189] ts 14 to 16; ts 41 to 43.
[190] Exhibit 1, tab 13.

(a) Dr Ramasamy did not think the Aboriginal Liaison Officer was available when he first reviewed Child R and felt that they would have been able to better convey his information to the family which may have generated more trust in his treatment for Child R;[191]

(b) Dr Ramasamy had difficulty in getting a history of Child R from her family and that while he had a good therapeutic relationship with Child R's mother, when he was speaking with her, he recalled that other family members were talking argumentatively and there were some inconsistencies in the information being provided to him;[192]

(c) These difficulties escalated when Dr Ramasamy sought to insert an IV cannula for the purpose of giving Child R an IV fluid bolus, with other family members (not being Child R's mother) feeling that he was harming Child R;[193]

(d) There was some time taken in securing the consent to the IV cannulation, in circumstances where Child R urgently required the fluid bolus to address her dehydration.[194]

**283.** Following his telephone conversation with Dr Nemba at Broome Hospital, Dr Ramasamy felt it was better to hand back the care of Child R to Dr Allen to avoid further unnecessary distress for the family about his involvement in her care and treatment.[195]

**284.** This was not an optimal outcome for Child R, because by then Dr Allen was well into her duties at the GP Outpatient Clinic. Child R would have benefited from greater continuity of care and, as I have outlined earlier in this finding, she should have remained in the Emergency Department, where she could have been more closely monitored, on an ongoing basis. This would have been under the continued care of Dr Ramasamy.

**285.** In the circumstances, given the seemingly intractable difficulties in the relations between Dr Ramasamy and Child R's family, with family members unhappy and reported to be shouting, the Aboriginal Liaison Officer contacted Dr Allen for her to be involved in Child R's care again. Once this level of escalation has been reached it becomes impractical, if not

[191] ts 107.
[192] ts 106 to 107.
[193] Exhibit 1, tab 23; ts 106 to 107.
[194] Exhibit 1, tab 23.
[195] ts 100.

impossible, for the one Aboriginal Liaison Officer to address the relationship difficulties.[196]

**286.** Dr Allen, assisted by the Aboriginal Liaison Officer talked to the family and secured their consent at approximately 11.00 am for Child R to be transferred to Broome. It would have been in the interests of Child R if such consent had been secured by the time of Dr Allen's 8.30 am telephone conversation with Dr Nemba. It was a dynamic and changing environment and shows how the involvement of an Aboriginal Liaison Officer can assist in clarifying communications and expediting decisions.[197]

**287.** Dr Allen reported not feeling safe, and that the work environment felt chaotic for her. These are a reflection of the escalation in the misunderstandings that day. Her feelings underscore the importance of support for clinicians in such circumstances, who are better able to carry out their duties when a culturally safe environment is proactively promoted by an institution. There are self-evident challenges in seeking to encourage a culturally safe environment reactively, after an adverse event or a series of events.[198]

**288.** The following clinical impressions concerning the reasons for Child R's elevated heart rate (some of which are referred to previously in this finding and summarised here) could have been better formulated if a culturally safe environment was better resourced, and therefore more readily available. The treating doctors substantially ascribed Child R's elevated heart rate to the presence of her agitated family:

**(a)** There were evident difficulties in the interactions with family members, experienced by the treating doctors from an early stage. They did not understand and were therefore not able to address promptly and effectively, the agitation being expressed by Child R's family. Dr Allen felt there was a history behind it, that she was unaware of;[199]

**(b)** When Dr Ramasamy examined Child R at 9.30 am, he felt the family's anxieties were contributing to Child R's distress and anxiety. This is repeated in her medical records;

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[196] Exhibit 1, tabs 13 and 23; ts 19 to 20.
[197] ts 22; ts 33 to 34.
[198] Exhibit 1, tab 13; ts 20.
[199] Ibid.

(c) In her 12.30 pm telephone conversation, Dr Allen suggested to the Royal Flying Doctor Service that the family's agitation was contributing to Child R's heart rate going up. At this point a request was made for Child R's family members (other than her mother) to leave the room.[200]

**289.** At times throughout her ordeal, Child R was screaming. She was in pain. It is now known that she was severely unwell. Her breathing became laboured. This is more likely to be the substantial reason for Child R's distress, anxiety, and elevated heart rate.

**290.** However, on the day, the potential causes of Child R's elevated heart rate were in part ascribed to the conduct of her family. It is more likely to be the other way around, and that it was Child R's dire condition that was causing the family's agitation.

**291.** The family's agitation could be more helpfully understood within the context of their worry and concern about Child R being in significant pain and their confusion about the reasons for the steps being taken in her medical care and treatment. On the other hand, the family's agitation and distress was experienced by some of the clinicians as disruptive and on occasion, confronting.

**292.** At the inquest Dr Phillips testified as to her understanding that within the context of cultural sensitivity and cultural safety, it needs to be recognised that family is "*really important*", and that Child R's mother may have wanted her family members to be there to support her. Dr Phillips suggested that an option may have been to have a maximum of four family members in the room with Child R.[201]

**293.** In Dr Phillips' opinion, Child R was in a lot of pain. She outlined some of the steps that might have been taken, to assuage the family's concerns about Child R's medical treatment. Her evidence was that an important step concerned Child R's need for strong pain relief on that day, sooner than she got it:

> "*…. that [pain relief] might have allowed the distress that escalated in the parents and the family watching difficult things being done to a probably screaming child, there was room for everybody involved in that to advocate for that child. The parents,*

[200] Exhibit 1, tab 17.
[201] ts 309.

> *the nursing staff, the doctors, the ALO – whoever was around, could have advocated to say, 'Hang on a minute. Can we just think – let's just start again. Let's get some Fentanyl. Let's get some Ketamine. Let's just calm and we will approach it again.' So that could have been done.*"[202]

**294.** The role of the Aboriginal Liaison Officer is highly important in such instances, but it should not be assumed that the involvement of this one officer could "*solve*" all potential misunderstandings once a certain level of agitation and discord is reached. The better approach is to consider how such an escalated situation can be avoided in the first place.

**295.** At the inquest Dr Phillips explained that where the consent of the parent or guardian cannot be secured, an application may be made to her, through the paediatrician, for a 72-hour holding order, for the child to come into the care of the hospital, in order for necessary medical treatment to be undertaken. Dr Phillips was not recommending this; she was responding to a question asked of her about the process. It is understood by all that this would be an extreme case and there can be implications in terms of ongoing trust with the hospital staff, moving forward.[203]

## Better resourcing

**296.** In considering how this escalated and tragic situation could have been avoided, I have discounted the use of a 72-hour holding order (a late-stage emergency measure) and looked towards earlier measures that could have better supported Child R, had they been resourced:

### (a) Better primary health care facilities

Better primary health care facilities in Halls Creek would have assisted Child R, to reduce the risk of patients like her repeatedly presenting to Halls Creek Hospital as an emergency patient, very unwell. Child R appears not to have been administered, or taken, her Movicol medication for approximately six weeks before her death, and there are likely to be complex reasons for this, as already outlined in this finding.

[202] ts 292 to 293.
[203] ts 291 to 292.

The Halls Creek Child Health Nurse had had a longstanding contact with Child R and her family, much of it at the Halls Creek Community Health Centre. She was involved in encouraging and supporting Child R's mother to attend medical appointments for Child R. The Child Health Nurse used to go into Halls Creek Hospital to fetch Child R's medication for her mother. The Child Health Nurse went on leave in late December 2016. By late 2016 Child R's mother had run out of the Movicol medication. A continued and active engagement by another clinician with Child R's mother during this leave period may have resulted in Child R receiving and taking her required daily medication, Movicol.

At the inquest Dr Ramasamy emphasised the importance of an accredited primary health care service adequately staffed with clinicians and support staff, including Aboriginal clinicians. The independent expert Dr Nair acknowledged some of the difficulties generally experienced in providing health care in remote and rural communities.[204]

There have been some improvements in WA Country Health Service's primary health care service at Halls Creek since the time of Child R's death and these are outlined later in this finding. A number of my recommendations, directed towards improvements in the area of primary healthcare also appear later in this finding.

**(b)** **<u>Better cultural awareness training</u>**

The misunderstandings as between Child R's family and the treating doctors referred to previously, may have been avoided, or ameliorated, with better cultural awareness training for the clinicians. Dr Allen's evidence was that she had received the WA Country Health Service's mandatory on-line cultural awareness training, but that she had not had any cultural awareness training that was local to Halls Creek. Dr Ramasamy also referred to this on-line training, and he referred to face-to-face training, though he could not recall if it had occurred in respect of the Halls Creek community. Dr Ramasamy's evidence was that regular training of doctors in indigenous cultural issues is crucial and suggested that it should be done on a more regular basis.[205]

[204] Exhibit 1, tabs 13, 20, 23 and 24; ts 120 to 121.
[205] ts 42; ts 111.

The improvements in WA Country Health Service's cultural awareness training appear later in this finding.

**(c) Better representation of Aboriginal healthcare workers within the country health system, and more Aboriginal Liaison Officers**

The misunderstandings referred to previously may also have been avoided, or ameliorated, with the employment of Aboriginal healthcare workers, and certainly with the employment of more than one Aboriginal Liaison Officer at Halls Creek Hospital. It is understood that the employment of Aboriginal healthcare workers is an ongoing and longer-term aim within the WA Country Health Service and is a matter that is very much supported within that Service.

The WA Country Health Service's improved steps towards an increase in the number of Aboriginal Liaison Officers and Aboriginal healthcare workers appear later in this finding.

**(d) Better resourced hospital at Halls Creek**

I have no criticism of the individual doctors that treated Child R. The standard and quality of their medical care was adequate, within the limits of the systems and processes available to them.

I have considered the standard and quality of the medical care provided by Halls Creek Hospital to Child R. Dr Allen's evidence was that, from an early stage she did not think it would be appropriate to manage Child R in Halls Creek, which as it transpired was correct.

At the inquest Dr Allen explained that due to a lack of facilities at Halls Creek, she was unable to conduct tests such as an ultrasound, an abdominal x-ray, a white blood cell count or a c-reactive protein test. Testing for a raised white blood cell count or an elevated c-reactive protein test might have given rise to a concern about sepsis at an early stage, though this cannot now be known.[206]

[206] Exhibit 1, tab 24; ts 15

It was not disputed at the inquest that an age-related reference range chart was not readily available to assist in interpreting Child R's blood test results that did become available on the i-STAT machine at 10.05 am, and that, if understood, would have revealed the severity of her dehydration.[207]

It is understood that facilities for performing ultrasounds and x-rays represent a significant commitment, in terms of the equipment, its maintenance and the qualified personnel to operate them. An assessment as to the viability of specific equipment and upgrades is outside the scope of the inquest, but a consideration of the potential for a better resourced hospital is not. A better resourced hospital at Halls Creek may have assisted Dr Allen in resolving her differential diagnoses.[208]

A culturally informed understanding of Child R's background may also have assisted the clinicians. The medical records and some of the evidentiary material reflects a focus upon the role Child R's mother, with respect to prior missed medical appointments, and Child R's missed medication in the weeks prior to her death.

However, it will also be seen from Child R's medical background, referred to earlier in this finding, that throughout Child R's life, her mother, assisted by her own mother, was very attentive towards Child R's complex medical needs, and cared for her in the home assiduously and consistently.[209]

It is important to consider why the missed appointments and missed medication may have occurred, within the context of the difficulties that Aboriginal persons face in access to healthcare, including access to transport, and financial barriers. The importance of culturally appropriate care in healthcare settings should be recognised, as it encourages a greater level of confidence and therefore a greater engagement with the healthcare system.[210]

A better resourced hospital at Halls Creek, within the context of the greater availability of Aboriginal Liaison Officers and/or Aboriginal healthcare workers, may have encouraged a greater engagement with

[207] Exhibit 1, tab 24; ts 279.
[208] ts 15.
[209] Exhibit 1, tabs 20 and 24.
[210] Exhibit 1, tab 28.

Child R's family, and avoided the misunderstandings that occurred on the day of her presentation.

It may have assisted at an even earlier stage, in the weeks before her death, by helping Child R's mother fully understand the importance of the daily medication Movicol and its consequences if it was missed for a period of time.[211]

## Quality of medical care

**297.** Through its lawyer the SSO, the WA Country Health Service argues that Halls Creek Hospital's standard and quality of medical care for Child R should be considered against the standard of care "*expected*" of a hospital in a regional and remote area, such as the East Kimberley region.

**298.** I have carefully assessed this argument. Whilst it is understood that a hospital in Halls Creek cannot provide the standard of care available in the metropolitan area in Perth, or even that available at its closer centre in Broome, there are limits to this argument.

**299.** With the passage of time, more has been understood about the health needs of Aboriginal persons, their vulnerabilities, and the social determinants of ill health. In previous inquests I have addressed the lasting and adverse repercussions, upon Aboriginal persons, of past historical policies.

**300.** These are profound, and they cross generations, as outlined by Professor Sandra Thompson, Professor of Rural Health, University of Western Australia in her report to me in connection with a previous inquest. Professor Thompson was addressing the general experience of Aboriginal persons in healthcare settings and considered some of these effects: "*Many Aboriginal people report on past personal or on the collective community experience of discrimination in health care settings and that the policies and practices of hospitals are not attentive to or support their needs. This reflects a form of institutional racism.*"[212]

**301.** I have addressed the tragic effects of intergenerational trauma and the importance of cultural continuity and cultural wellbeing within the context

[211] Exhibit 1, tab 7.
[212] Exhibit 1, tab 28.

of Aboriginal persons' connection to country in my finding on inquest into the deaths of 13 children and young persons in the Kimberley Region.[213]

**302.** Through her lawyer the ALS, Child R's mother submits that there was a collective failure on the part of Halls Creek Hospital to provide Child R with an "*appropriate and professional service*" due to a range of matters, including miscommunications and lack of suitable facilities. My attention is drawn to Dr Thompson's classification of institutional racism, referred to above, that draws upon such factors.[214]

**303.** Through its lawyer the SSO, WA Country Health Service strongly denies that institutional racism was involved in the treatment of Child R.

**304.** Dr Thompson linked the failure of an organisation to provide an appropriate and professional service to a causative element, namely that the adverse impacts of such failures are endured by persons "*because of their colour, culture or ethnic origin*". [215]

**305.** I am satisfied that the individual clinicians worked to the best of their ability to try to treat, and then to try and save, Child R, and that none of them displayed any form of racism towards her.

**306.** However, at the material time, Halls Creek Hospital could have been better equipped, in terms of some of the medical equipment, and the cultural support for Child R's mother.

**307.** In considering the WA Country Health Service's argument, it is readily apparent that if a more limited standard of care is "*expected*" of a hospital in a regional and/or remote area (for example with less medical testing available, stretched resources, limited cultural supports) this may impact disproportionately upon Aboriginal persons. It is a question of the degree of the limitations. If these limitations are taken too far, they risk being perceived as a form of institutional racism, however unintentional.

**308.** I urge the WA Country Health Service to consider its argument about the standard of care to be "*expected*" of a hospital in a regional and remote area such as the East Kimberley, and to place some parameters around it. The

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[213] *https://www.coronerscourt.wa.gov.au/I/inquest_into_the_13_deaths_of_children_and_young_persons_in_the_kimberley_region.aspx*
[214] Exhibit 1, tab 28.
[215] Ibid.

Kimberley Region has a very high proportion of Aboriginal persons as compared with the proportion across the State as a whole.

**309.** While I do not consider that at the material time, Halls Creek Hospital's medical services were impacted by institutional racism, the understanding of this concept is evolving.

**310.** On all of the evidence before me, I am satisfied that the standard and quality of medical care provided by Halls Creek Hospital to Child R on 5 January 2017 was below the standard that should be expected of a public hospital in that area. Matters that I have taken account of include the impacts of the transfer out of the Emergency Department, the lack of an age-related reference range chart, the delay in administration of the phosphate enema and the overall time it took to arrange for Child R's transfer out of Halls Creek.

**311.** I have taken account of some of the substantial improvements at Halls Creek Hospital, which are addressed later in this finding under the heading *Improvements*.

**312.** Nonetheless further consideration is warranted, on the part of WA Country Health Service, regarding the expected standard of care in regional and/or remote hospitals.

## Dr Allen's working conditions

**313.** Dr Allen was the District Medical Officer at Halls Creek Hospital. In that role she was a GP. She did not hold additional specialist qualifications.[216]

**314.** At the inquest the independent expert Dr Nair having reviewed the medical records, considered that Dr Allen's initial assessment of Child R was very comprehensive and thorough. I accept his opinion.[217]

**315.** I have considered the appropriateness of Dr Allen being responsible for both the GP Outpatient Clinic patients and Child R's ongoing management on the ward as the admitting doctor after 9.00 am. This would not have arisen as a concern if Child R had been kept in the Emergency Department. However, she was not kept there.

[216] ts 8 to 10.
[217] ts 214.

**316.** Through its lawyer the SSO, the WA Country Health Service submits to me that part of the role of a rural generalist, such as Dr Allen, is to balance the different roles such as attending to a GP roster and being on call for admitted patients. Further, that it is appropriate for a doctor who is rostered to a GP Outpatient Clinic to be able to respond to a call for a deteriorating admitted patient if that occurs during their shift.

**317.** WA Country Health Service acknowledges that it can be difficult for a doctor who may feel that they need to be in two places at once, but that prioritisation of patients is key (as well as asking for assistance), and in such situations GP patients may need to wait while a deteriorating patient on the ward is attended to.

**318.** Within limits I accept this argument. I also note the subsequent improvements referred to by WA Country Health Service in the form of a more robust Emergency Telehealth System, with emergency clinicians available 24 hours a day 7 days a week, to provide additional support to rural and remote doctors.

**319.** However, some further attention needs to be given to the WA Country Health Service's expectation that rural generalists be able to routinely prioritise (as well as ask for assistance) particularly where a potentially deteriorating patient is concerned. Such practices sound reasonable in theory, but an examination of the demands placed upon Dr Allen that day, and the resources available to her, shows that they can be difficult to implement.

**320.** The margin for error in a remote location, in a small hospital, was (and remains) very narrow. There may be limited options for reversal when a patient's condition deteriorates. The role of the rural generalist, as described by WA Country Health Service may not leave enough time for reflection on the part of the doctor, to consider their differential diagnoses and assess for deterioration, or improvement. Again, this is a question of degree. An assessment of the job descriptions of individual clinicians is outside the scope of the inquest, but as before, a consideration of the potential for a better resourced hospital is not.

**321.** Turning back to the role of Dr Allen as the rural generalist, it makes it even more important for Child R to have remined in the Emergency Department, where she could have been more actively monitored, with continuity of care.

**322.** Dr Allen reported having previously been reprimanded for spending too long with Emergency Department patients when she should have been attending to the patients at the GP Outpatient Clinic, and that she was open to being told what to do because she was new. This reprimand was a matter that Dr Phillips said she found disturbing because, worldwide, it is an axiom that emergencies always take priority.[218]

**323.** I am satisfied that it was not practical or appropriate for Dr Allen to be responsible for both the GP Outpatient Clinic and Child R's ongoing management as the admitting doctor, after 9.00 am.

**324.** I turn now to Dr Allen's working hours.

**325.** Dr Allen left Halls Creek Hospital at approximately 7.15 pm on 5 January 2017, when the ambulance left the hospital with Child R on board. She would not know at that time that Child R would shortly be returned to the hospital in that ambulance, for resuscitation.[219]

**326.** It needs to be acknowledged that by this stage, Dr Allen had been on duty for an extended period of time (though not of it all on site at Halls Creek Hospital). She commenced her shift at Halls Creek Hospital at 1.00 pm on 4 January 2017, working on site until 11.00 pm or midnight. She remained on call overnight until 8.00 am on 5 January 2017. She was rostered to start work at the GP outpatient clinic from 9.00 am. It was her third week working at Halls Creek Hospital and she reported that she found it a difficult environment to adapt to.[220]

**327.** She remained on site at Halls Creek Hospital and the GP Outpatient Clinic throughout the day on 5 January 2017. As she was heading home, at approximately 7.25 pm (some 10 minutes after she had left) she received a call to come back to Halls Creek Hospital because Child R had gone into cardiac arrest in the ambulance. She spoke with the family, who were greatly upset, and then walked into the ward and went to the resuscitation room to try to assist.[221]

**328.** These working hours are long and can be difficult to bear. It is understood that there are a range of support and/or counselling services available for the staff of the WA Country Health Service after traumatic events. Some

[218] ts 32 to 33; ts 310.
[219] Exhibit 1, tab 13.
[220] Exhibit 1, tab 13; ts 8 to 10.
[221] Exhibit 1, tab 13; ts 29.

attention could be helpfully given by WA Country Health Service to improved resourcing so that the burden of these long hours is minimised, in the interests of a safe and supported environment for both patients and doctors.

## SAC 1 investigation should have been held

**329.** A SAC 1 clinical incident investigation (being an investigation into a Severity Assessment Code 1 clinical incident) was not held by WA Country Health Service in respect of Child R's death. The Department of Health's Clinical Incident Management Policy classifies an incident as a SAC 1 where it is considered that the death was contributed to by the health care.

**330.** At the inquest, Dr Phillips testified that a SAC 1 investigation should have been held. This view was shared by the independent expert Dr Nair. A SAC 1 investigation is important step, that can promptly and significantly contribute to the process of learning from mistakes and/or preventing future deaths.[222]

**331.** Through her lawyer the ALS, Child R's mother submits to me that it would have been preferable for a fulsome investigation to have been done at the time, through a SAC 1 process. I accept this submission.

**332.** Through its lawyer the SSO, WA Country Health Service accepts that, with the benefit of hindsight a SAC 1 investigation ought to have been undertaken in respect of Child R's death (explaining that it was not done because that at the time, WA Country Health Service had considered that Child R's death was not contributed to by the health care provided to her).

**333.** WA Country Health Service draws attention to their endeavours in speaking with staff members and family members after the death but acknowledges that important issues regarding Child R's admission were not addressed in that process.

**334.** At the inquest Dr Nair referred to a practice he is familiar with in another jurisdiction, that provides for a psychologist to be present during a SAC 1 investigation. He explained that in such forums the psychologist is able to provide clinicians with insights into what the family of the deceased person is experiencing, and also ensure that the clinicians' feelings are managed and

[222] ts 268 to 269; ts 285 to 286.

supported. In his experience, the inclusion of the psychologist has been most helpful.[223]

**335.** At the inquest Dr Phillips was very supportive of the inclusion of a psychologist in a SAC 1 investigation process, and felt it was a matter she would take on board and consider.[224]

**336.** Through its lawyer the SSO, WA Country Health Service submits that adequate psychological support is already in place, external to the SAC 1 process, pointing to a range of supportive measures for staff members that are external to the SAC 1 process. They also submit that families are provided with support through the open disclosure process.

**337.** I have taken account of this submission. I nonetheless consider that the process whereby an involved psychologist is able to provide clinicians with insights into what the family of the deceased person is experiencing can be helpful from a therapeutic perspective. It may also be helpful in assisting clinicians through the process of learning from mistakes and/or preventing future deaths. The matter is further addressed in my *Recommendations*, later in this finding.

## IMPROVEMENTS

**338.** It is clear that WA Country Health Service reflected upon lessons learnt from Child R's death, and a number of improvements have been implemented, including (and not limited to) the ones I outline below. They are also part of the Service's own adherence to a process of continual improvement.

### Culturally responsive health service improvements

**339.** Through its lawyer the SSO, WA Country Health Service acknowledges the importance of cultural awareness training and draws my attention to a number of initiatives, after the time of Child R's death, directed towards their improvements in continuing to provide culturally safe and secure services for Aboriginal persons, as follows:

**(a)** There are now two Aboriginal Liaison Officers at Halls Creek Hospital (one male and one female) and an additional Aboriginal Liaison Officer is to be appointed to assist the visiting specialists

[223] ts 265.
[224] ts 296 to 297.

from Kununurra, with the aim of encouraging attendance at scheduled appointments, and assisting with them;

**(b)** An Aboriginal interpreter is now available at Halls Creek Hospital;

**(c)** An Aboriginal Governance Committee headed by a senior and respected Aboriginal Consultant has been established, with the aim of fostering employment of Aboriginal persons within the WA Country Health Service; my attention is drawn to the engagement of an Aboriginal nurse and an Aboriginal doctor in Broome;

**(d)** Career pathways for Aboriginal persons are being developed for Aboriginal healthcare workers, including transition to nursing programs for Aboriginal Liaison Officers;

**(e)** An Aboriginal Leadership and Management Program has been established, with the aim of improving health outcomes by engaging with Aboriginal persons interacting with the health system; my attention is drawn to the fact that 16 Aboriginal staff members graduated from that program the previous year;

**(f)** Social workers will be engaged in regional Emergency Departments, in recognition of the socioeconomic burdens prevalent in some of those regions;

**(g)** A newer on-line cultural awareness training program, that is mandatory for all WA Country Health Service staff members (replacing the 2015 one) addresses relevant matters including the cultural determinants of health, historical and contemporary factors impacting Aboriginal persons' health and wellbeing, and implicit bias and systemic racism;

**(h)** Face-to-face cultural awareness training is arranged locally in the Kimberley Region, including Halls Creek; whilst COVID-19 restrictions impacted on this in about 2021, re-engagement with local providers, exploration of availability and monitoring of training is now occurring;

**(i)** A new senior position of Aboriginal health practitioner is being considered, for this person to work clinically and culturally with Aboriginal persons in regional Emergency Departments, particularly with chronic disease management, and empowering Aboriginal persons in that management;

(j) A position for a nurse practitioner (also known as a nurse navigator) has been created, funded and advertised; the nurse practitioner is to be responsible for the coordination of care for children with complex medical needs in the East Kimberley area, with a focus on their medical management plans, regular monitoring, and review; the nurse practitioner is to liaise with the visiting paediatric team; at the inquest, Dr Phillips confirmed that Child R would have come within the remit of this nurse practitioner, for monitoring and care coordination; whilst the WA Country Health Service submits that this role should not be limited to a nurse practitioner, I note the process of engaging this nurse has commenced, and given the role, am satisfied it would be more appropriately filled by a nurse;

(k) A position for a practice nurse has been created, funded and advertised; this role is responsible for the provision of practice nurse and manager services for the Halls Creek Hospital GP Outpatient Clinic; In Dr Ramasamy's opinion, this practice nurse would be dedicated to primary health care, working together with Aboriginal healthcare workers and GP's; at the inquest, Dr Phillips supported this;

(l) The GP Remote Vocational Training Scheme has been introduced for the Halls Creek Hospital Outpatient Clinic with the aim of training, supervising and supporting a local doctor; whilst it has been difficult to recruit to the position due to the remote supervision model, WA Country Health Service remains supportive of this scheme at Halls Creek Hospital.[225]

**340.** WA Country Health Service has considered and implemented a range of initiatives to support the delivery of a culturally responsive health service, and Aboriginal persons have been substantially involved in their design.

**341.** Through her lawyer the ALS, Child R's mother highlights the importance of face-to-face cultural awareness training specific to the regional area in which the staff will be working and I agree that greater emphasis should be placed upon it. I note that re-engagement with local providers is occurring, post COVID-19, and it is my expectation that this will be assiduously followed up and implemented.

[225] ts 120; ts 287 to 291; ts 301; ts 311.

**342.** These are some important improvements in the area of primary health care, directed towards earlier engagement with patients to avoid, if possible, repeat Emergency Department presentations. I note however that some of the new employment positions that have been initiated have been difficult to fill and/or that it may be difficult to retain the staff in those positions.

**343.** In order to further support a health service that is responsive to, and supportive of, the needs of Aboriginal persons, having regard to their connection to country and culture, I have made recommendations in this area that appear later in this finding.

## Access to electronic medical records – WACHS

**344.** After the time of Child R's death, WA Country Health Service – Kimberley implemented access to iSoft electronic medical records system (including outpatient summaries, clinic letters and discharge summaries) for clinicians at all their sites.[226]

**345.** Dr Allen had not previously seen or treated Child R. If, at the material time, Dr Allen had access to the iSoft electronic medical records, it may have alerted her to the unusual features of Child R's presentation on 5 January 2017 (including the vomiting and abdominal distension, that were not typically present during her previous presentations with constipation for bowel washouts).[227]

## Access to electronic medical records - RFDS

**346.** After the time of Child R's death, since approximately December 2021 the Royal Flying Doctor Service (WA) has had access to the medical information, to the extent that it is entered on the WA Country Health Service iSoft electronic medical records system.

**347.** There are ongoing discussions between WA Country Health Service and Royal Flying Doctor Service (WA) about the merits and challenges associated with gaining real-time access to relevant portions of the WA Country Health Service's medical record.

**348.** Given the work that is already being undertaken to facilitate the further access, that can assist with decisions surrounding priority, tasking, mode of

[226] Exhibit 2, tab 30.
[227] Ibid.

transport and timing for patient transfers, there is no need for me to make a recommendation in this area.

## State-wide electronic medical record

**349.** In addition to the access to iSoft electronic medical records referred to above, a much broader and more comprehensive project is under way.

**350.** Through its lawyer the SSO, the WA Country Health Service informs the court that consideration is being given to a State-wide electronic medical record. Steps have commenced towards introducing its precursor, namely a Digital Medical Record at a number of sites.

**351.** The court is informed that the project is being driven by the Department of Health. WA Country Health Service has consulted with the Department of Health, continues to do so, and remains eager for its introduction.

**352.** In describing the potential for safer and more reliable health care in the event of the introduction of the State-wide electronic medical record, Dr Phillips refers to similar systems already implemented in other jurisdictions that will: "*…. allow health care professionals to access and update patient information in a platform that is real time. Vital signs are automatically uploaded to records and early warning alerts trigger if a patient's condition deteriorates. The platforms allow for patient engagement via a patient portal and telehealth capability*."[228]

**353.** Within the context of the limited role of the WA Country Health Service as indicted to the court, there is no need for me to make a recommendation concerning the introduction of a State-wide electronic medical record.

## Emergency Telehealth Service

**354.** The Emergency Telehealth Service clinician was unavailable when contacted in respect of Child R. This contact was sought to be made after 3.00 pm on 5 January 2017, after Child R's condition had become patently dire. I accept Dr Phillips' assessment that this was unlikely to have affected Child R's treatment and care at that point, because when contact could not be made with the Emergency Telehealth Service clinician, the clinicians at

[228] Exhibit 2, tab 30.

Halls Creek Hospital promptly made contact with the Broome paediatricians for advice.[229]

**355.** However, I have considered the desirability for earlier contact being made with the Emergency Telehealth Service, before a child's condition becomes dire. At the inquest the independent expert Dr Nair drew attention to the particular benefits of the Emergency Telehealth Service. For example, by means of the videoconferencing facility the clinicians in the Emergency Department of a tertiary hospital can see the child in a hospital in a more remote area. In describing some of the benefits of contacting senior clinicians through the Emergency Telehealth Service Dr Nair pointed to the following:

> "*They can see the child. I tell them what I'm doing in front of them, and they say, yes, they agree, or "please do this and please to that", and I think it's really important.*"[230]

**356.** After the time of Child R's death, further guidance was given for the usage of the Emergency Telehealth Service by the WA Country Health Service. It is mandated for use for Category 1 triage score cases across the Kimberley Region. Further, the guidance given is that in paediatric cases, a very low threshold should be used to activate the call. Through its lawyer the SSO, WA Country Health Service informs the court that the Emergency Telehealth Service is now more robust with emergency clinicians available 24 hours a day, seven days a week.[231]

**357.** It will be recalled that Dr Allen had noted that Child R looked unwell. This was an important clinical assessment. With the threshold for making contact with Emergency Telehealth Service being lowered in paediatric cases, and a more robust service being available, a child who looks unwell can be reviewed by senior clinicians through the videoconferencing at an early stage. This is a helpful development, as it is well known that an unwell child can deteriorate very quickly. As Dr Nair explained, with respect to children:

> " *…. their physiology is different they compensate, they compensate, they compensate, and then finally they crash. But it's – it's the critical thing in paediatrics is to recognise that compensation and say, "You're compensating, you're compensating. I need to act because you're compensating, because*

[229] Ibid.
[230] ts 264.
[231] Exhibit 2, tab 30.

*I know there will come a point where your system will just give up." Children do that. Adults don't do that*."[232]

## Age related reference range chart

**358.** After the time of Child R's death, the Department of Health produced a chart showing the i-STAT age and gender related biochemistry reference ranges. This information if available at the material time, would have assisted the clinicians in better identifying the severity of Child R's dehydration.[233]

**359.** Through its lawyer the SSO, WA Country Health Service informs the court that this chart has been distributed to all its sites, and specifically confirms that the chart is in place at the i-STAT machines at the hospitals in Broome, Kununurra and Halls Creek.

**360.** By reason of this improvement there is no need for me to make a recommendation concerning a chart for the reference ranges for children.

## SAC 1 investigations – Aboriginal persons

**361.** At the inquest, the independent expert Dr Nair raised the importance of an Aboriginal person being present in the room during a SAC 1 investigation and questioned how that review can be done without that "*cultural lens*", a perspective that was also supported by Dr Phillips.[234]

**362.** Through its lawyer the SSO, WA Country Health Service informs the court that in August 2022 a change was made to the SAC 1 Business Rules that requires, within 48 hours of a SAC 1 event occurring, the determination of an investigation team "*including Aboriginal person participation in investigations concerning an Aboriginal patient, consumer or client*." The intent is for this person to be an Aboriginal employee. It is being monitored by the Board, that advises that since this change, all SAC 1 investigations have been complaint with it.

**363.** By reason of this improvement there is no need for me to make a recommendation concerning the participation of an Aboriginal person in a SAC 1 investigation concerning an Aboriginal patient who has died.

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[232] Exhibit 1, tab 13; ts 22; ts 49; ts 256.
[233] ts 280.
[234] ts 266; ts 298.

## RECOMMENDATIONS

**364.** The following recommendations, concerning the ongoing filling of certain roles, are directed towards improvements in primary healthcare in Halls Creek. It is understood that steps have been taken in these areas, but also that the filling and/or retention of staff in some of these roles has been challenging. The recommendations are made with the aim of encouraging WA Country Health Service to exercise all reasonable efforts to fill them and keep them filled:

***Recommendation No. 1***

**I recommend that the position of a nurse practitioner, also known as a nurse navigator, be filled on an ongoing basis, to undertake the care and co-ordination of children with complex needs in the East Kimberley region, and that this person be trained in cultural awareness appropriate to the region (including face-to-face training) and be trained to provide the service in accordance with trauma informed principles.**

***Recommendation No. 2***

**I recommend that the position of nurse practitioner be filled on an ongoing basis to provide practice nurse and practice manager services at the Halls Creek GP Outpatient Clinic, and that this person be trained in cultural awareness appropriate to the region (including face-to-face training) and be trained to provide the service in accordance with trauma informed principles.**

***Recommendation No. 3***

**I recommend that the GP Remote Vocational Training Scheme at the Halls Creek Hospital GP Outpatient Clinic continues to be supported and that any difficulties recruiting to the position be addressed as far as is practicable. Also, that this person be trained in cultural awareness appropriate to the region (including face-to-face training) and be trained to provide their services in accordance with trauma informed principles.**

**365.** The following recommendation is directed towards improvements in the processes for the Severity Assessment Code 1 (SAC 1) investigations. It has been reported to the court that an Aboriginal person now participates in SAC 1 investigations concerning an Aboriginal patient who has died, and this is a significant improvement. This recommendation is made with the aim of encouraging WA Country Health Service to consider further improvement in the form of steps towards a trauma informed SAC 1 process:

***Recommendation No. 4***

**I recommend that, in relation to SAC 1 investigations, steps are taken to ensure that a psychologist is involved, with the aim of supporting a trauma informed process.**

## CONCLUSION

**366.** Child R died just over 12 hours after she presented to Halls Creek Hospital, due to the complications of an intestinal obstruction, that arose due to faecal impaction. The doctors at Halls Creek Hospital consulted with a specialist paediatrician at Broome Hospital, with a view to consideration of transfer of Child R to Broome Hospital.

**367.** Throughout the course of the day the doctors at Halls Creek Hospital endeavoured to treat Child R. Due to a combination of factors outlined in this finding and relating broadly to the limits of the systems and processes available to them at Halls Creek Hospital, the seriousness of Child R's condition was not initially apparent to them. Later that day, when the seriousness of Child R's condition became more apparent, they endeavoured to stabilise her, without success.

**368.** By the time the arrangements were commenced to transfer Child R to Broome Hospital, towards the middle of the day, Child R's condition had deteriorated. Her condition continued to deteriorate at an escalating rate throughout the afternoon.

**369.** When the Royal Flying Doctor Service arrived to collect her in the late afternoon, Child R was dying, and could not be saved.

**370.** This inquest highlighted the need for better resourced primary care services in Halls Creek, and better resourcing of the Halls Creek Hospital. It also highlighted the importance of culturally safe health services, that would benefit the patients, their families and the treating clinicians, in regional and/or remote areas.

**371.** Child R was in significant pain and discomfort throughout the day. Her evident pain could have been alleviated at an earlier stage with some stronger pain relief.

**372.** It cannot now be known whether an early transfer to Broome Hospital would have saved Child R's life, but I have no doubt it would have been in her best interests to be so transferred, with a greater opportunity afforded to her for prompt and effective medical treatment.

**373.** Child R's mother and her family continue to feel the pain from the loss of their beloved child.

R V C FOGLIANI
**STATE CORONER**
29 June 2023