JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	SARAH HELEN LINTON, ACTING STATE CORONER
HEARD	:	20-22 MAY 2025
DELIVERED	:	26 MARCH 2026
FILE NO/S	:	CORC 844 of 2024
DECEASED	:	DHAR, SANDIPAN

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W Stops assisted the Coroner.
Mr G Donaldson SC (Dominion Legal) appeared for Joondalup Health Campus, including Dr Harwood, Dr O'Hearrain and Nurse Rocchiccioli.
Mr K Lendich SC with Ms K Reynolds (Avant Mutual) appeared for Dr Allen, Dr Prabhaker and Dr Rana.
Mr M Williams (Panetta McGrath) appeared for Dr Siow.
Mr P E Jarman (Maurice Blackburn) appeared for the Dhar family.

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

Nil

(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Acting State Coroner, having investigated the death of ***Sandipan DHAR*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, PERTH, on 20 May 2025 - 22 May 2025, find that the identity of the deceased person was* ***Sandipan DHAR*** *and that death occurred on 24 March 2024 at Joondalup Health Campus, Corner Of Grand Boulevard and Shenton Avenue, Joondalup, from complications of acute lymphoblastic leukaemia in the following circumstances:*

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INTRODUCTION

1. Sandipan Dhar was a much loved little boy who died suddenly at the age of 21 months at Joondalup Health Campus (JHC) on 24 March 2024. He died from complications of an infection on a background of undiagnosed acute lymphoblastic leukaemia. Sandipan had been seen by three different GPs and doctors at JHC Emergency Department (ED) in the month or so prior to his death, including as late as 22 March 2024, but his leukaemia had not been diagnosed. If it had, it would have created an opportunity for Sandipan to receive treatment for the leukaemia that would very likely have saved his life. Accordingly, I directed that an inquest be held, in accordance with s 22(2) of the *Coroners Act 1996* (WA) (the Act), to consider what missed opportunities in Sandipan's medical care could be identified that might have saved Sandipan's life, and what lessons can be learned from his tragic death?

2. All of the clinicians involved in Sandipan's care leading up to his passing, from both the GP practice and JHC, have reflected on these sad events and provided statements and reports on the care they provided to Sandipan. Some were also called to the inquest to answer questions to assist in understanding what happened and what can be learned as a result.

3. In addition, the Court received documentary evidence in the form of a number of expert reports and expert reviews, and also heard oral evidence from some of the expert witnesses involved, in relation to the reasonableness of the medical care provided.

4. The following witnesses gave evidence during the inquest:

   a. Dr Robert Allen, GP, assessed 19 February 2024.

   b. Dr Chinniah Prabhakar, GP, assessed 14 March 2024.

   c. Dr Sanjeev Rana, GP, assessed 20 and 22 March 2024, referred to JHC.

   d. Carlo Rocchiccioli, JHC RN, assessed 22 March 2024.

   e. Dr Caolan O'Hearrain, JHC ED RMO, assessed 22 March 2024.

   f. Dr Yii Wen Siow, JHC Supervising ED Consultant, assessed 22 March 2024.

   g. Dr Christa Bell, Senior Emergency Physician and Paediatrician, JHC External Review Report Co-Author.

   h. Dr Shahina Braganza, Senior Emergency Physician. JHC External Review Report Co-Author.

   i. Dr Kevin Hartley, JHC Director Medical Services.

   j. Assoc Prof Luke Lawton, ED Physician Expert.

   k. Suresh Rajan, Community Advocate.

   l. Sanjoy Dhar, Sandipan's father.

5. Sandipan's family have fully engaged with the investigation process, despite the fact they are still struggling with the immense grief at losing their beloved son and

brother in such circumstances. They provided their personal recollections of events to the initial inquiries that were conducted as well providing written statements, and as noted above, Mr Dhar gave oral evidence at the inquest.

6. Mr and Mrs Dhar seek answers to how their son's death from a curable illness could have happened, given they repeatedly sought medical help for Sandipan. The Dhar family want lessons to be learned from this tragic case so they can be reassured that other families will not needlessly suffer in the same way. They find solace in their son Mrinal and daughter Oikantika, but there will be an eternal hole in their family as a result of losing Sandipan and their grief will forever impact all of their lives. Mr and Mrs Dhar have been respectful of the need for the coronial process to run its course. I am grateful for their patience and understanding and I hope that this finding will give them some of the answers and reassurance they seek, for themselves and Sandipan's brother and sister.

7. However, as I mentioned was likely during the inquest hearing itself, there are some conflicts in the evidence that I am unfortunately unable to resolve. It is not unusual for witnesses faced with traumatic events to have different recollections of key aspects, and it does not necessarily follow that one of them must be lying. As was noted in the submissions, what is remembered about an event is shaped by how that event was experienced, by conditions prevailing during attempts to remember, and by events occurring between the experience and the attempted remembering."[1] Added to that are the difficulties of remembering with whom one has spoken, if there are interactions with more than one person and on more than one date, as is the case here, and the possibility of miscommunication and misunderstandings due to language or cultural differences, which is also a factor in this case.

8. Where there are differences on important issues, I have endeavoured to set out both versions of events and any explanation I can identify for why there may be a divergence in the evidence, as well as any conclusions I consider I am able to reach. In doing so, I emphasise that I accept that all the witnesses sought diligently to recall matters and give their evidence truthfully and accurately. However, there are reasons why I have preferred the evidence of one witness over another at various times.

9. When assessing the evidence in this matter and resolving inconsistencies, as well as determining whether I should make any adverse findings or comments, I have been mindful of two key principles. The first is the phenomenon known as 'hindsight bias', which is the common tendency to perceive events that have occurred as having been more predictable than they actually were.[2]

10. The medical experts in this case were very conscious of the risk of hindsight bias when giving their opinions. One of the experts commented in his report that the, "role of an expert reviewer is a privileged one – with knowledge of the outcome, it is easy to be wise after the event and to look retrospectively at where things could have been different when the outcome is a specific diagnosis, rather than to be fair and put oneself in the shoes of the doctor in question who was dealing with uncertainty and

[1] Submissions filed on behalf of Dr Siow, dated 31 July 2025 [1].
[2] See for example: www.britannica.com/topic/hindsight-bias.

complex situations."[3] The same can, to an extent, be said of a coroner, who has the benefit of knowing the trajectory that led to the outcome, and to hear evidence from experts as to how, if things had been done differently, that outcome could have been avoided. Therefore, I have taken the same care to try to avoid hindsight bias in reaching my conclusions.

11. The second principle, which is known as the *Briginshaw* principle, is derived from a High Court judgment of the same name, in which his Honour Justice Dixon observed:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "*reasonable satisfaction*" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[4]

Essentially, the *Briginshaw* principle requires that the more serious the allegation, the higher degree of probability that is required before I can be satisfied as to the truth of the allegations. I have applied the *Briginshaw* principle where I consider it appropriate given the gravity of the conclusion, rather than simply reaching all of my findings on the balance of probabilities, which is the usual standard in a coronial inquiry and noting that under s 41 of the *Coroners Act 1996*, the rules of evidence do not apply.

12. To assist me in reaching my conclusions, and to resolve the conflicts in the evidence where possible, I have been assisted by submissions from the interested parties, which have helpfully covered a number of topics that were identified during the inquest as possible areas of conflict that I may wish to try to resolve. I have given due consideration to these submissions in formulating my findings and I am grateful to the careful and respectful manner in which counsel have set out the relevant evidence, paying attention in particular to these areas of contention, and their acknowledgement that some of the evidentiary issues may not be able to be resolved in this inquiry.

13. I am mindful that my task is to find answers, where possible, as to what caused Sandipan's death and the circumstances around how his death occurred. As part of that task, it is appropriate to also consider whether we can learn any lessons for the future in terms of public health and safety. I am expressly precluded from making findings that might suggest any person is guilty of any offence or that would appear to determine any question of civil liability, although I do have the power to refer evidence to a disciplinary body if I consider it appropriate.[5]

14. No one involved in this inquest has been left untouched by Sandipan's death. The Western Australian community has also collectively expressed its sadness and

[3] Exhibit 1, Tab 16, pp. 7 – 8.
[4] *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 362.
[5] Sections 25 and 50 *Coroners Act 1996*.

concern that this could happen to any child in this State. However, the sorrow of the witnesses and general community can never match the level of profound grief and loss experienced by Sandipan's family. Nothing can bring back their beloved son and brother, but I hope they take some comfort from the fact the community of Western Australia has mourned with them, and Sandipan will not be forgotten.

KEY LARGO MEDICAL CENTRE

15. Sandipan was born on 14 June 2022 in Perth. He was the second born son of his parents, Sanjoy and Saraswati Dhar. He had an older brother, Mrinal. Sandipan lived with his parents and brother in Butler. He loved his older brother and wanted to be with Mrinal all the time. Sandipan was generally a happy and healthy little boy who was growing up normally. Sandipan had been reaching his developmental milestones, was eating well, learning to walk and also learning to speak in three languages (Bengali, English and Hindi). Until just prior to his death, his parents had never had any reason to take Sandipan to see a physician or specialist, with all of his medical needs being addressed by nurses and general practitioners at his local medical centre.[6]

16. Sandipan was registered as a new patient at the Key Largo Medical Centre (the medical centre) in Clarkson shortly after his birth. Sandipan was given his routine immunisations at the medical centre on three occasions without any noted incident or concern at the time or afterwards.[7]

17. On 14 February 2024, Sandipan jumped off a bed onto the floor and hurt his leg. His parents took him to the medical centre on 15 February 2024 to have him medically assessed and make sure everything was okay. Sandipan was reviewed by GP Dr Robert Allen. Dr Allen recalled he was told Sandipan had previously been walking, but after jumping from the bed he had reverted to crawling. Dr Allen thought Sandipan appeared to be a well child during the assessment. No record was made of his temperature, but Dr Allen was confident Sandipan's temperature was normal as he would otherwise have made a note. Dr Allen observed Sandipan continued to neglect his left leg and withdrew it when Dr Allen palpated it. The working diagnosis was a musculoskeletal injury, such as a minor sprain. However, Dr Allen sent Sandipan to have an x-ray on his left leg to rule out a subtle buckle injury (fracture) of the lower leg. Sandipan's parents were also told to give him Nurofen (ibuprofen) for any pain and to return for follow-up a few days later if they did not hear from him. The x-ray was reported on 15 February 2024 as normal.[8]

18. Sandipan's parents took him back to the medical centre on 19 February 2024 for review by Dr Allen. His limp had resolved and he was now walking normally.[9] Sandipan was recorded as meeting all his developmental milestones and appeared to be bright and happy during the assessment. Dr Allen became aware that Sandipan was due to have his 18-month vaccinations at this time. He made a note that

[6] Exhibit 1. Tabs 10, 10.1 and 10.2.
[7] Exhibit 1, Tab 11.
[8] T 34 – 36, 39; Exhibit 1, Tab 10.
[9] Exhibit 1, Tab 10 and Tab 19.

Sandipan had no history of vaccine reactions, was reported to be well on that day and had not experienced any fevers in the last seven days. There were no contraindications to Sandipan receiving his vaccinations that day, so arrangements were made for Sandipan to be given his 18 month vaccines by a nurse at the medical centre after he had been seen by Dr Allen. Sandipan's parents later told police they were a little unsure, given Sandipan had been taking medication due to his leg, but they were guided by the recommendations of the health professionals that it was safe and appropriate and they gave their written consent.[10]

19. The nurse who administered the immunisations made a note that Sandipan was afebrile (not feverish) at that time, with a normal temperature of 37.1°C. After being given the immunisations, Sandipan showed no immediate adverse reaction and he was taken home by his parents.[11]

20. Two days after the injection, Sandipan's parents noticed the vaccination site turned into a little red pimple, which then later changed to a brown dot and then a black dot. Mr Dhar and his wife were a bit worried about this reaction as Sandipan also had a temperature. They told police they called and spoke to a nurse at the medical centre who explained that it was quite normal after vaccinations for him to run a temperature and advised them to give Sandipan Panadol or Nurofen. They followed this advice but he did not improve.[12]

21. There was evidence before me that it is rare for there to be a vaccination wound, although sometimes there can be a small lump, which is often secondary to the immune response. It should usually settle within the 24 to 48 hour mark and it was suggested it would be an unusual clinical presentation for a vaccination site not to have settled after three weeks, although some (such as a tuberculosis vaccination) can leave a residual mark for much longer. It could also be a small haematoma or bruise. However, after three weeks it seemed to be generally agreed that it would be worth considering whether there were signs of infection if there continued to be a concern about the injection site.[13]

22. Sandipan's parents remained worried about him and they decided to take him back to the medical centre to see a doctor again. Sandipan's parents brought him back to the medical centre approximately three weeks after the previous appointment, on 14 March 2024. This time they saw GP Dr Chinniah Prabhakar. Dr Prabhakar had seen Sandipan once before for an immunisation about a year before, but had not seen him since that time.[14]

23. On this occasion, Dr Prabhakar recalled that Sandipan's parents had brought him in as his father wanted the doctor "to check his ears and check him generally,"[15] as he had been feeling hot and cold, running a temperature and pulling on his ears for the past week. Dr Prabhakar recorded in Sandipan's notes that his parents reported he

[10] T 37 – 38, 46; Exhibit 1, Tab 10 and Tab 19.
[11] T 38 – 39; Exhibit 1, Tab 11 and Tab 19.
[12] T 43; Exhibit 1, Tab 10.
[13] T 43 – 45.
[14] T 51; Exhibit 1, Tab 11 and Tab 18.
[15] T 50.

had a fever and was unwell. Dr Prabhakar examined Sandipan's ears and did a general examination. His temperature was 36.6°C, so he did not have a fever at the time of examination (noting now there is evidence his parents gave him Panadol before they attended), and Dr Prabhakar recalled all his other observations were within normal limits. Sandipan also seemed active and playful. Dr Prabhakar noted Sandipan's ears seemed fine. His throat appeared red, but there was no pus on his tonsils and the tonsils were not enlarged. Dr Prabhakar did not recall examining the vaccination site or having the site itself raised with her by Sandipan's parents. Dr Prabhakar explained to Sandipan's parents that his throat might be red due to a viral illness (with no focus of infection) and advised them to give him simple Panadol or Nurofen and monitor him for any worsening symptoms, on the understanding they could bring him back if he got worse.[16]

24. Sandipan's father indicated in his statement that he recalled they asked Dr Prabhakar about any medications or tests (including blood tests) that might be required at that stage, but were reassured that nothing was required and other than his temperature, all his observations were stable, except for Sandipan looking a little pale. Sandipan's father recalls they were told to give him Panadol and "just to keep an eye on him."[17] I also note Mr and Mrs Dhar do not accept that they were concerned about Sandipan's ears during the appointment and that a physical examination was performed. Noting that ultimately there was no expert evidence before me to suggest the GP care was inappropriate or unreasonable, and given there were more conversations with other doctors after this appointment, including conversations about how long he had experienced fever, I have not attempted to reconcile these differences.

25. Sandipan's parents brought their son back to the medical centre again, just under a week later, on 20 March 2024. They had remained concerned as Sandipan continued to have a temperature at home. Sandipan was seen by another GP at the practice, Dr Sanjeev Rana, as Dr Prabhakar had limited availability. Dr Rana has a diploma in child health, in addition to his GP Fellowship, and has worked as a GP since 2021 at the medical centre and another practice. Dr Rana had not seen Sandipan before this day but he was aware from the medical records that Sandipan had been in to see Dr Prabhakar at the centre five or six days previously. Dr Rana was also aware from the notes that Sandipan had received some vaccinations there a few weeks ago and understood the problems started after having those vaccinations.[18]

26. Dr Rana took a history from Sandipan's parents. They recall they told Dr Rana that Sandipan's temperature had not dropped since 19 February 2024 (about a month before) and they were worried. Dr Rana remembered that Sandipan's father's opening statement was that Sandipan had been having a fever for two weeks before, although he agreed Sandipan's father also mentioned his belief that the fever had started after Sandipan injured his leg and then received the vaccination, back in February, and he was worried the problem might relate to the vaccination. Dr Rana recalled Sandipan's father raised a concern about the vaccination site, which he said had appeared red and bruised for some time, although it had eventually settled down.

[16] T 50 – 60; Exhibit 1, Tab 11 and Tab 18.
[17] Exhibit 1, Tab 10 [21].
[18] T 64 – 65. 94; Exhibit 1, Tabs 10, 10.1 and 10.2, Tab 11 and Tab 15.

Dr Rana also recalled Mr Dhar mentioned that over the previous two weeks Sandipan had recorded a fever, then Sandipan had been afebrile (no fever) for two days around the time he was seen by Dr Prabhakar, before the fever had returned again five or six days previously and had remained. Dr Rana understood that Sandipan's parents had been giving him Panadol to bring his temperature down and on that day they had given him Panadol before they came to see him for the consult.[19]

27. Dr Rana noted there was no clear source for the fever, based upon the history Sandipan's parents provided. His urine and bowel movements were reported to be normal and he had not had a cough, rash or runny nose. Dr Rana also observed that Sandipan appeared generally well in appearance.[20]

28. When Dr Rana tried to examine Sandipan, he was very irritable and difficult to examine. Sandipan's parents told Dr Rana Sandipan was not normally like this at home and they had noticed the change since his last vaccinations. Dr Rana thought Sandipan might have been scared remembering the pain of the injection, which was making him uncooperative. Dr Prabhakar recorded Sandipan's temperature as 37.3°C but within the context that his parents had given him Panadol before they had brought him to the medical centre, which had possibly lowered his temperature. Sandipan's parents advised his temperature had been 37.8°C the night before. Sandipan's chest was noted to be clear and his ears had mild redness on the right ear drum but were otherwise normal. His throat, however had exudates on his tonsils on both sides, suggesting an infection. Dr Rana also noticed Sandipan had dry lips, which sometimes in the context of prolonged fever could indicate vasculitis/Kawaski disease, so he expanded the examination to look for any rashes, but could not find anything. Dr Rana also looked for the vaccination site and could only find a healed scab. Dr Rana gave evidence he had been looking for signs of cellulitis at the site, but he was reassured that there was no infection present and the site had healed.[21]

29. After considering the history and following the physical review, Dr Rana found Sandipan was a well looking child with no symptoms or signs to suggest a severe underlying illness such as sepsis, meningitis, pneumonia, vasculitis, intraabdominal infection, UTI, cellulitis or any other common causes of fever. His only notable feature on examination were his inflamed tonsils, which were a potential cause of the reported fever.[22]

30. Dr Rana was asked at the inquest whether he saw a dark spot on the roof of Sandipan's mouth during this first review, noting Mr and Mrs Dhar recall it being mentioned at the time. Dr Rana gave evidence he did not recall seeing a dark spot. He believes if he had seen one he would have referred Sandipan to hospital at the end of the first consult, as a purpuric spot can be one of the signs of vasculitis and he was looking for signs of this at the time as part of a differential diagnosis.[23]

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[19] T 64 – 66; Exhibit 1, Tab 10, Tab 11 and Tab 15.
[20] T 66 – 67, 72; Exhibit 1, Tab 11 and Tab 15.
[21] T 69, 90 – 91; Exhibit 1, Tab 11.
[22] Exhibit 1, Tab 15.
[23] T 89 – 90; Exhibit 1, Tabs 10.1 and 10.2.

31. Based upon his findings, Dr Rana decided to treat Sandipan for the obvious tonsillitis with the oral antibiotic Phenoxymethylpenicillin, which is the first line choice antibiotic for tonsillitis. Dr Prabhakar also told his parents to continue to give him Panadol, as needed, and to bring him back for review in two days' time. Dr Rana gave evidence he appreciated at the time that Sandipan's parents were worried about his prolonged fever. He did not think the tonsillitis was the cause of the prolonged fever, but he thought it was possible Sandipan may have been experiencing recurrent bouts of illness and had picked up tonsillitis five or six days before, after the break in his fever when he saw Dr Prabhakar. Nevertheless, he recognised the high level of parental concern and that is why he wanted to see Sandipan again for review in a couple of days.[24]

32. After leaving the medical centre, Mr and Mrs Dhar went to a pharmacy in Butler and filled the prescription for the antibiotics. They then commenced giving the antibiotic to Sandipan as prescribed. However, he did not get better and continued to have a fever.[25]

33. Sandipan's parents brought Sandipan back to see Dr Rana again two days later on 22 March 2024, as planned. They felt more confidence in Dr Rana than the other GPs at this time as he had seemed thorough, so they were content to see him for follow up. Dr Rana noted Mr and Mrs Dhar presented as concerned parents and Mr Dhar, in particular, openly expressed that he was still worried. He commented that Sandipan had been experiencing a fever for about three weeks and antibiotics hadn't worked. Sandipan also now had a runny nose and a mild cough. In that context, and with his primary concern around the prolonged unexplained fever, Mr Dhar asked if they could do a blood test.[26]

34. Dr Rana noted that Sandipan appeared irritable, miserable and clingy to his mum on examination. He had a mild, wet sounding cough, a runny nose and his tympanic (ear) temperature was recorded by Dr Rana as elevated at 38.3°C. His chest was clear but Sandipan's throat still showed exudate on the left tonsil, despite starting antibiotics. The high temperature indicated to Dr Rana that Sandipan definitely had an infection somewhere, and at this point in time Dr Rana was no longer quite sure about his diagnosis of tonsillitis given the failure to respond to the appropriate antibiotic. Dr Rana gave evidence that taking into account the level of parental concern, his uncertainty about the diagnosis and Mr Dhar's request for a blood test, he decided at this stage to send Sandipan to hospital for review.[27]

35. Sandipan's parents remember the events slightly differently. They recall they were told that they should wait a few more days to see if he got better but they "insisted the doctor give us a referral to Joondalup Hospital."[28] Dr Rana conceded in evidence he was probably not as concerned as Mr and Mrs Dhar at this time, but he also said he couldn't ignore their obvious parental concern that their son might have a serious

[24] T 72 – 74; Exhibit 1, Tab 11.
[25] Exhibit 1, Tab 10.
[26] T 74 – 75; Exhibit 1, Tabs 10, 10.1 and 10.2.
[27] T 75 – 78, 93 - 94; Exhibit 1, Tab 11 and Tab 15.
[28] Exhibit 1, Tab 10 [28].

condition. They were hoping it might be clarified by a blood test, and Dr Rana agreed to provide a hospital referral in that context.[29]

36. Dr Rana explained at the inquest that he would normally just give a patient a pathology form for the blood test and they could have taken it to the phlebotomist at the clinical laboratory that operates from the same building at the medical centre. However, given Sandipan was a young child and he was already irritable, Dr Rana thought it would have been very hard to try and have the blood collected as an outpatient. Dr Rana knew Sandipan's parents were keen for him to have a blood test to try to identify why he had been experiencing prolonged fever, and he considered that this could most appropriately be done in hospital. Dr Rana also gave evidence that along with the blood test, he assumed other investigations might also be required to find the exact cause of the fever, and if Sandipan required intravenous antibiotics he would need to be admitted under a paediatrician. Therefore, Dr Rana wrote a referral letter to the Emergency Department doctors at JHC and gave it to Sandipan's parents at the end of the appointment.[30]

37. In the letter, Dr Rana set out the history of Sandipan's recent presentations to the medical centre and specifically mentioned that he had been treated with penicillin for the last two days but "he continues to have fever and his parents are worried as it's been going on for last 3 weeks."[31] Dr Rana recorded his impression that the differential diagnosis could be tonsillitis or Epstein Barr Virus (glandular fever) but that other causes could be investigated for his ongoing temperature for the last three weeks. Of some importance, Dr Rana also wrote that Sandipan "would need bloods, urine" done as well as possibly intravenous antibiotics.[32] Dr Rana indicated that it was his usual practice to refer a febrile child to the hospital if he thinks they need a septic screen, which he was suggesting by this notation.[33]

FIRST PRESENTATION TO JHC – 22 MARCH 2024

38. Sandipan's parents drove straight from the medical centre to JHC.[34] JHC is the largest healthcare facility in Perth's northern suburbs and provides 24-hour acute care from birth to old age. It is comprised of a standalone 150-bed private hospital and a co-located hospital that provides services to public patients under a public/private partnership with the WA Government. JHC is managed by Ramsay Health Care (Ramsay) and reports to the North Metropolitan Health Service on a range of performance indicators, as part of the overall WA Department of Health. JHC's ED is one of the busiest in Western Australia and treats over 96,000 patients a year, with 24% of those paediatric patients. A little over a quarter of those patients are admitted overall, although for paediatric patients the figure is closer to 10%. [35]

[29] T 78, 81, 93 – 94; Exhibit 1, Tabs 10.2 and 10.2.
[30] T 78 – 83, 85 – 87; Exhibit 1, Tab 11 and Tab 15.
[31] Exhibit 1, Tab 11, Referral letter to JHC ED dated 22.3.2024, p. 2.
[32] Exhibit 1, Tab 11.
[33] T 80 – 81, 86; Exhibit 1, Tab 15.
[34] Exhibit 1, Tab 10.
[35] Exhibit 1, Tab 14, pp. 21 – 23; Exhibit 2.

39. Medical records show Sandipan was seen for triage in the JHC ED at 2.06 pm. The primary assessment noted Sandipan was "warm/hot" with a rapid pulse and an increased temperature of 38.4°C. The presenting problem was documented as:[36]

> *Paediatric fever past 2 days reduced oral intake by a lot as per parents. Normal wet nappies. Some loose stools. Had redness and swelling on vaccination site to leg, now scabbed over. Cough. Respiratory Rate 32.*

40. Sandipan was given a triage score of 3, which is urgent. He remained in the waiting room for a period of about two hours before Registered Nurse Carlo Rocchiccioli was allocated to care for Sandipan in the ED's paediatric pod. Nurse Rocchiccioli escorted Sandipan and his family from the waiting room into a cubicle around 4.30 pm. Nurse Rocchiccioli then began performing a nursing assessment of Sandipan and documented his findings in the Integrated Progress Notes and in the Paediatric Acute Recognition and Response Observation Tool (PARROT) chart. Nurse Rocchiccioli recalled that Sandipan's GP had written a referral letter for him and said it would have been in the triage file, but he wasn't sure if he read the letter. He did recall speaking to Sandipan's parents and reading the triage notes in conjunction with performing the physical assessment.[37]

41. Mr Dhar gave evidence that he ran Nurse Rocchiccioli through Sandipan's history, starting with the night Sandipan fell and hurt his leg through to that day and how they had come to be at the ED. He mentioned seeing Dr Rana that morning and Mr Dhar gave evidence he particularly mentioned that they were there at the ED for a blood test. Mr Dhar recalled they discussed Sandipan's cough as Sandipan was coughing at the time of their discussion.[38]

42. Nurse Rocchiccioli was aware Sandipan had been taking oral antibiotics for suspected tonsillitis and Sandipan had been given some vaccines some time before. He understood Sandipan had been referred to hospital by his GP for investigation of ongoing fever. Nurse Rocchiccioli examined Sandipan's injection site as part of his physical assessment and noted it was scabbed over and not abnormally red. Sandipan appeared to be breathing normally but he was crying, with an occasional wet cough. He was unable to take a blood pressure reading as Sandipan resisted. Nurse Rocchiccioli noted Sandipan was alert, but seemed tired and grizzly and was clinging to his mother. His heart rate was elevated at 172 beats per minute, but Nurse Rocchiccioli thought this was potentially due to his distress. Sandipan's temperature was within normal limits at 37.3°C (down from 38.9 °C when he was in the waiting room), noting he had received Panadol and Nurofen by this time. His capillary refill time, which can indicate a septic child, was normal. Other than his elevated heart rate, all of Sandipan's vital signs were within normal limits.[39]

43. Nurse Rocchiccioli gave evidence at the inquest that although the temperature had reduced by the time he saw Sandipan, he was aware of the history of recurring fevers and that his fever could have been masked by Panadol, so he would not have ignored

[36] Exhibit 1, Tab 12, Triage Form 22.3.2024.
[37] T 101 – 102; Exhibit 1, Tab 12, pp. 70 – 75 and Tab 23.
[38] T 446 – 447.
[39] T 103 – 106; Exhibit 1, Tab 12, pp. 70, 75 and Tab 23.

the possibility that Sandipan still had a fever. However, it was relevant that it had improved with analgesia. Further, temperature is not a factor in determining the Early Warning Score on the PARROT chart, so it did not influence the score for Sandipan that day.[40]

44. Sandipan's PARROT score was 4, with 3 points coming from his elevated heart rate and 1 from parental concern (which is a binary measurement of 0 or 1). Nurse Rocchiccioli explained at the inquest that Sandipan was very distressed during the examination, which in his experience is quite common with young children as they don't like being touched by nurses or other clinicians. Nurse Rocchiccioli noted that Sandipan was distressed next to the heart rate reading, to reflect the possibility the distress had caused the increased heart rate. He explained he would usually come back and observe from afar and see if the heart rate drops back into a normal range once the child has settled.[41]

45. With a PARROT score of 4, it was recommended that Sandipan receive timely medical review, within half an hour. As it happened, he was seen in a very timely manner, as a doctor came to see Sandipan before Nurse Rocchiccioli had finished.[42]

46. Nurse Rocchiccioli was still conducting his assessment of Sandipan when they were joined by Resident Medical Officer (resident) Dr Caolon O'Hearrain. Dr O'Hearrain was working as a resident with the East Metropolitan Health Service at the time. He was based at Royal Perth Hospital but was undertaking a rotation at JHC as part of his training and had been allocated to work in the paediatric pod that day. He had worked in the paediatric pod before at JHC and was quite familiar with the area.[43]

47. Dr O'Hearrain was working under the supervision of Emergency Consultant Dr Yii Siow. Dr Siow was working at JHC as an Emergency Consultant part-time, where she was responsible for managing complex cases and mentoring junior medical staff. That afternoon/evening Dr Siow had been allocated to work as the supervising Emergency Consultant in the paediatric pod in the ED. Dr Siow was supervising an intern, one or two residents and possibly a junior registrar. Dr Siow recalled it was a typical busy day, with constant demands and multiple tasks requiring attention. This was consistent with the JHC statistics, which showed the number of patients, and specifically paediatric patients, was high but consistent with current averages. The nursing and medical staffing was adequate based on usual rosters.[44]

48. Dr Siow was managing her own patients as well as managing the care of the resident's and intern's patients. Dr O'Hearrain was one of the residents on shift. Dr O'Hearrain had worked under Dr Siow's supervision previously and he would generally assess patients and formulate a possible diagnosis and treatment plan before consulting Dr Siow. Based on previous shifts working together, it seems both

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[40] T 107.
[41] T 105 – 108; Exhibit 1, Tab 12, p. 75 and Tab 23.
[42] T 105 – 108; Exhibit 1, Tab 12, p. 75 and Tab 23.
[43] T 109, 130; Exhibit 1, Tab 22.
[44] Exhibit 1, Tab 13, pp. 13 – 14.

doctors had a good working relationship and a general level of confidence and trust in each other to perform their respective roles.[45]

49. Dr O'Hearrain saw Sandipan for the first time at around 4.40 pm. He recalled it was not an overly busy shift, which explains why he was able to come and see Sandipan so quickly. Nurse Rocchiccioli had completed his physical assessment of Sandipan around this time, so he let Dr O'Hearrain take over while he went about documenting his notes. When asked whether, in hindsight, he could recall anything that stood out from his assessment, Nurse Rocchiccioli gave evidence he recalled Sandipan was pale at the time he reviewed him and the wound on his leg was slightly unusual, but nothing else stood out. He stated he had thought Sandipan looked like "quite a well child all over,"[46] but he also took comfort in the fact that he was being reviewed by the RMO immediately.[47]

50. Mr Dhar gave evidence he ran through the history with Dr O'Hearrain and repeated every single thing he had already mentioned to Nurse Rocchiccioli. Mr Dhar recalled he specifically mentioned to Dr O'Hearrain as well that they were there in the ED for a blood test. Mr Dhar recalled Dr O'Hearrain responded that he would not be the one to make that decision, and in effect indicated it would be made by a more senior doctor.[48]

51. Dr O'Hearrain recalled in evidence that he introduced himself to the family and asked what brought them in that day. They fairly succinctly told him that "their son had been having a fever for the past couple of weeks. They had gone to their GP a few times, and the GP … had sent them in looking to get blood done."[49] They mentioned the GP had diagnosed tonsillitis and had commenced Sandipan on antibiotics, and they mentioned his vaccination, with the site on one of his legs.[50]

52. As well as speaking to Mr and Mrs Dhar, Dr O'Hearrain also had a distinct recollection of reading the GP referral letter, although he couldn't recall if Sandipan's parents handed him the letter or if it was in the bundle of medical records prepared by the ED triage staff. Dr O'Hearrain noted that whilst the GP's letter was helpful, it was incumbent on him to collect his own medical history from the parents and conduct his own assessment of Sandipan.[51]

53. Dr O'Hearrain documented in the medical notes that Sandipan had been referred by the GP with fever and decreased appetite. He understood Sandipan had experienced intermittent fevers for 20 days, for which he had been taking Panadol, and his fevers had hit 38.5°C. Sandipan had received his 18 month vaccinations three weeks before in his right thigh. Sandipan had shown a decreased appetite for one week and slightly reduced fluid intake. He was urinating well with regular wet nappies but had loose stools the day before and cold symptoms recently, including a sore throat and runny

[45] T 109, 130; Exhibit 1, Tab 20 and Tab 22.
[46] T 109.
[47] T 102, 108 – 109; Exhibit 1, Tab 12, p. 70 and Tab 23.
[48] T 447.
[49] T 132.
[50] T 132.
[51] T 131, 196 – 197; Exhibit 1, Tab 22.

nose, but no cough/shortness of breath, no rash and no lethargy. He had started penicillin two days before for tonsillitis and was advised to present to the ED if the fevers or symptoms persisted.[52]

54. Dr O'Hearrain noted the physical observations that had been recorded and he also conducted his own physical examination. The findings included that Sandipan appeared distressed, in the sense of being upset and crying, but not physically unwell. He had an increased heart rate of 170, but his observations were otherwise within normal limits. Although persistent tachycardia can be concerning, Dr O'Hearrain was aware that a child's heart rate can elevate if they are upset and crying and he thought this could have been a contributing factor in Sandipan's case. Sandipan was afebrile at that time, although it was noted he had been given Panadol and Nurofen in the waiting room to help with his fever and pain. Dr O'Hearrain tested Sandipan's capillary refill and noted it was less than 2 seconds, which is normal. His heart sounds were normal and his chest was clear. His ears were normal on examination and there were no infective signs on his vaccination site. Dr O'Hearrain said he specifically checked the site as a skin infection could have been the source of the fever. He noted a little scab but nothing more concerning. Dr O'Hearrain said he palpated Sandian's abdomen and it was soft and non-tender. Of note, Dr O'Hearrain recorded seeing white spots (exudate) on Sandipan's left tonsil, which looked to him like tonsillitis.[53]

55. Dr O'Hearrain estimated his assessment/examination of Sandipan took somewhere between 5 to 10 minutes to complete and he read Dr Rana's referral letter as part of that process. He understood from the letter, and from his initial discussion with Sandipan's parents, that they were expecting Sandipan to undergo a blood test. Dr O'Hearrain agreed in evidence he understood that Dr Rana was effectively suggesting a septic workup in his referral letter, with the bloods, urine and possibly intravenous antibiotics all a part of that picture.[54]

56. Overall, and consistent with Dr Rana's impression, Dr O'Hearrain formed the impression of 'viral tonsillitis'. The tonsillitis was consistent with the white spots seen on his left tonsil and would explain the fever. Dr O'Hearrain thought it was likely the tonsillitis was viral in nature as the penicillin he had been given did not appear to have had any effect and the other cluster of symptoms (runny nose, sore throat) are more often associated with a virus.[55]

57. Dr O'Hearrain gave evidence that the primary difference between the information provided by Dr Rana and his own impression from the information provided by Mr and Mrs Dhar was in relation to the fever. He understood from his discussion with Sandipan's parents that Sandipan's fever "came in waves,"[56] which differed from Dr Rana's description of a three-week constant fever. Although Mr Dhar did not use the word 'intermittent', that was Dr O'Hearrain's understanding from talking to Mr Dhar. Dr O'Hearrain indicated in his statement that he "thought the ongoing,

[52] Exhibit 1, Tab 12, p. 68.
[53] T 132, 137, 178 – 179, 198 - 201; Exhibit 1, Tab 12, p. 68.
[54] T 136, 139 - 140.
[55] T 132 – 133; Exhibit 1, Tab 22.
[56] T 136.

intermittent, fever was unusual."[57] However, given the history of vaccinations, which can cause a fever for a couple of days, and the evidence of current tonsillitis, Dr O'Hearrain thought at the time it was possible Sandipan had two consecutive sources of fever over the period of 20 days or so. Dr O'Hearrain gave evidence he would have been more concerned if Sandipan had been constantly feverish, had symptoms that suggested another source of the fever and/or the Nurofen and Panadol had not been helping. However, that was not his understanding at the time, noting as well that his temperature had dropped within the ED after being given Nurofen and Panadol, which was reassuring.[58]

58. Dr O'Hearrain then sought Dr Siow's advice in relation to his preliminary diagnosis and management plan. Dr Siow was positioned in the centre clinical station in the paediatric area and was free at that time, so they spoke immediately. Dr O'Hearrain couldn't recall specifically, but he believed he took the referral letter with him when he went to speak to Dr Siow on or near the 'flight deck'. He recalled he mentioned the referral letter to Dr Siow and basically paraphrased its contents, but he could not remember if he specifically showed Dr Siow the referral letter as part of their discussion. Dr Siow was also asked about the letter, and she recalled Dr O'Hearrain mentioned the GP letter to her, but she was certain she did not read it. Dr Siow explained in her statement she did not ask to read the letter herself as she trusted Dr O'Hearrain to tell her the relevant information contained in the letter.[59]

59. Dr O'Hearrain remembered telling Dr Siow that Sandipan had only taken two days dosage of a course of antibiotics, and his understanding was it was a five to seven day course. Dr O'Hearrain thought he might have mentioned Dr Rana's recommendation of a blood test, but he could not be certain.[60]

60. Dr Siow recalled Dr O'Hearrain advised the GP had referred Sandipan to the ED for review due to the 20 day history of fever that had started after an immunisation and because he hadn't responded to oral penicillin. Dr Siow also recalled Dr O'Hearrain described Sandipan's left tonsils as swollen and inflamed with some white spots on it. Dr O'Hearrain told Dr Siow his working diagnosis was tonsillitis, which was also the opinion of the GP. Dr O'Hearrain described the rest of his physical examination as unremarkable and she remembered Dr O'Hearrain described Sandipan's vitals as 'okay' or 'stable'. Dr Siow did not recall any mention of a blood test.[61]

61. Dr O'Hearrain's discussion with Dr Siow was relatively short, because as soon as he mentioned Sandipan's history of intermittent fevers over 20 days, Dr Siow started to walk towards Sandipan's cubicle to review him for herself. Dr Siow agreed in evidence that she was a little distracted during their conversation as she had become concerned when he mentioned 20 days of fever and wanted to review the child herself as soon as possible, so she moved quickly to the cubicle.[62]

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[57] Exhibit 1, Tab 22 [45].
[58] T 133 – 136, 139, 193; Exhibit 1, Tab 22.
[59] T 133 – 135, 142 – 144. 175, 179 – 180, 206 – 207, 237 - 238; Exhibit 1, Tab 20 and Tab 22.
[60] T 133 – 135, 142 – 144. 175, 179 – 180, 206 – 207; Exhibit 1, Tab 20 and Tab 22.
[61] T 237 – 238; Exhibit 1, Tab 20.
[62] T 208.

62. Dr Siow gave evidence that when she first saw Sandipan he was in his mother's arms and his father was standing nearby. She recalled Sandipan was not crying or distressed and she felt "very relieved" [63] that he actually looked well. Dr O'Hearrain had accompanied her and he was present in the cubicle when Dr Siow spoke to Sandipan's parents. Dr Siow asked Sandipan's parents why they had presented to the ED that day and they responded by describing the fever that had started after his immunisation. They said they had been to the GP several times and their son had been prescribed oral antibiotics but the fever had not subsided. Dr Siow gave evidence that it is not uncommon for a GP to refer a child to the ED for a second opinion, so this did not strike her as unusual.[64]

63. Dr Siow asked how long the fever had been present for and she recalled Mr Dhar told her it was 20 days. Dr Siow explored further as it was important to know if it was one long course of fever. She asked Mr and Mrs Dhar if it was a continuous fever or if there was a break in the fever and recalled Mr Dhar thought about it for a second and then told her there was a two-day break before the previous fever and the current fever, with the current fever having lasted seven days. Dr Siow was asked whether she might have misunderstood Mr Dhar advising there were two nights when they did not give him Panadol, as opposed to there being two days of no fever? Dr Siow was clear in her response that this was not the case and there was no misunderstanding. She was confident Mr Dhar told here there were two days without fever and then a further fever that had last seven days by that time.[65]

64. I note at this stage the evidence of a break in the fever is consistent with the evidence of Dr Prabhakar and Dr Rana's medical notes from 20 March 2024. Sandipan did not have a fever at the time Dr Prabhakar reviewed him on 14 March 2024 and Dr Rana's notes indicate that when Sandipan had been reviewed a few days' before at the medical centre, he had not had a fever for two days at that time and he confirmed at the inquest that was his understanding from speaking to Mr and Mrs Dhar.[66]

65. Dr O'Hearrain also recalled Mr Dhar explaining Sandipan's various episodes of fever to Dr Siow and it was his recollection that they were able to ascertain the fever had been intermittent and that there were periods of recovery between the episodes of fever. Dr O'Hearrain was asked if it might only have been the effect of the analgesic medications masking an ongoing fever, but he recalled understanding that the fever would go away for several days, so he "thought it was a mixture of meds and whatever was causing the fever, to be abating."[67] At the inquest he recalled there were at least two periods of recovery described, with at least three days elapsing in between.[68]

66. I note that Dr Siow and Dr O'Hearrain's recollections of the history given by the Dhars is consistent in the sense it was not a continuous fever, but there is a difference

[63] T 240.
[64] T 241; Exhibit 1, Tab 20.
[65] T 243, 342; Exhibit 1, Tab 20 [73] – [77].
[66] T 72; Exhibit 1, Tab 15 [5].
[67] T 208.
[68] T 208.

between what they understood about the number of breaks and the length of those breaks.

67. Dr Siow also asked if Sandipan had a cough or any other symptoms. She recalled Mr Dhar said Sandipan did not have a cough or any other symptoms and he was otherwise well.[69] Although it was suggested to her in questioning that this conflicted with the information provided by the GP and should have been explored, Dr Siow responded that in her experience the information provided by a patient and information in a GP letter often does not tally and the history can change, so if a patient is in front of her and a history is given that there is no cough, she will believe them. Dr Siow did not recall the parents mentioning any issues with his vaccination site, although she was aware he had recently had a vaccination.[70]

68. Dr Siow gave evidence she examined Sandipan for herself and made her own assessment of him. She started with his hands, trying to gauge some information about his perfusion and whether he seemed pale, and also assessed his breathing. She found no evidence of systemic distress, in the sense of him appearing lethargic, not responsive or with cold peripheries. Dr Siow looked at Sandipan's tonsils next and she observed his left tonsil was red and inflamed with some exudate on it, which is classic tonsillitis. Dr Siow did not observe a black spot on the roof of Sandipan's mouth during this examination. Sandipan started crying after the tonsillar examination, which apparently is not unusual, so his response did not concern Dr Siow.[71]

69. Dr Siow recalled she offered Sandipan's parents an opportunity to also look at Sandipan's tonsils. She remembered Mr Dhar initially agreed but then he changed his mind after Mrs Dhar expressed some concern, noting Sandipan was already distressed. Generally, Dr Siow had noted that Mr Dhar took the lead in speaking and Mrs Dhar was quieter. Dr Siow recalled generally their conversation around this time was light-hearted and she did not get the impression either parent was unhappy with how the consultation was progressing, although this is challenged by Mr Dhar and his wife, who remained very concerned for their son throughout their time at the hospital.[72]

70. After viewing Sandipan's tonsils Dr Siow's working diagnosis was tonsillitis, whether viral or bacterial. Given there had been no response thus far to the antibiotics and noting how well Sandipan looked, Dr Siow thought the source was more likely to be viral. She acknowledged that 20 days was a long time for a fever, but she took into account her understanding from the history given that that there had been two days of no fever, so she thought it could be a recurrent viral illness.[73]

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[69] T 243 – 244.
[70] T 244 – 245, 249, 337; Exhibit 1, Tab 20 [78] – [87].
[71] T 248 – 249.
[72] T 249; Exhibit 1, Tab 20.
[73] T 249 – 250.

71. After Dr Siow had examined and assessed Sandipan, including speaking to Sandipan's parents, a plan was formulated. Dr O'Hearrain documented the plan in the medical notes, which was recorded as:[74]

    a. Encourage fluids.
    b. UA (urine analysis).
    c. Resp PCR (swab for viral respiratory infections, such as COVID).
    d. Continue Abx course (continue his course of antibiotics).
    e. Advised to re-present Wednesday if symptoms persist.
    f. Xylocaine viscous (local anaesthetic for his throat).

72. The general evidence was to the effect this plan was the initial management plan, which could potentially need to be revised based upon the results of the PCR and urine test results. In relation to the notation to re-present on Wednesday if symptoms persist, Dr O'Hearrain was questioned about why that would be entered if the plan was to wait and see the results of the urine and PCR test before deciding if a blood test was required. Dr O'Hearrain gave evidence he made that entry at the direction of Dr Siow. He recalled he didn't ask specifically why it was Wednesday, but in his head he presumed it might have been to allow for the full course of antibiotics to be completed and then see if Sandipan's condition had improved. Dr O'Hearrain agreed in evidence the notation was inconsistent with the plan to revise the plan, if necessary, after the results were in from the other tests and suggested that perhaps he could have written more clearly that the note regarding re-presenting on Wednesday was predicated on Sandipan being first cleared for discharge.[75]

73. Dr O'Hearrain recalled that Dr Siow told Mr and Mrs Dhar her proposed management plan while still in the cubicle. He believed they appeared to accept the plan, which involved doing urine analysis and a respiratory swab for Covid and other viral illnesses, giving Sandipan a medication for his throat and encouraging him to drink fluids. He recalled Dr Siow told Sandipan's parents she didn't think blood testing was necessary at that time; they would wait for the results of the other testing (namely the PCR and urine test) first.[76] Dr O'Hearrain explained at the inquest that he remembered the discussions around blood testing were prompted by Dr Siow independently of any request from Mr and Mrs Dhar and related to a full blood count, which would usually take around an hour to an hour and a half to receive the results in the ED. It would not relate to a blood culture at that stage, which takes considerably more time.[77]

74. When asked how he gauged Mr and Mrs Dhar's acceptance of the proposed management plan, Dr O'Hearrain explained that "they didn't seem to openly disagree with it"[78] and he "didn't get an underlying sense that they had a dispute with it."[79] Dr O'Hearrain recalled they were very pleasant and very polite the whole time.

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[74] Exhibit 1, Tab 12, p. 69.
[75] T 149 – 150, 188, 191.
[76] T 146 – 147.
[77] T 164, 209.
[78] T 211.
[79] T 211,

Dr Siow also gave evidence that after explaining the plan to Sandipan's parents, she asked them at the end of the consult if they had any questions and they did not.[80]

75. It was suggested to Dr O'Hearrain that Mr and Mrs Dhar may have overheard the discussion around re-presenting on Wednesday if symptoms persist in the cubicle, which might have given them the impression it was alright to take their son home. Dr O'Hearrain accepted the discussion about returning on the Wednesday could have been misinterpreted at that moment in time.[81]

76. A PCR swab to test for viral infections was taken by Nurse Rocchiccioli at 5.10 pm and Sandipan's parents were left with a sterile specimen jar to obtain the urine sample. The urine testing was to see if the fever could have been caused by an infection, such as a urinary tract infection or kidney infection.[82] Dr Siow explained that the PCR test tends to take a while to come back, so she wasn't expecting the result to be back on the same day. As for the urine test, the hospital staff would do a dipstick after the collection, which would provide some preliminary information, but the sample would also then be sent to the lab for culture, which would take a couple of days. Dr Siow indicated that given these timeframes, she was not expecting Sandipan's parents to stay in the ED until the respiratory PCR tests came back, but she had wanted them to stay for the initial outcome of the urine test, as that could have changed the course of management. For example, if there had been a urinary tract infection present, it would have required different antibiotics to be prescribed. Dr Siow also indicated that this would have provided some assurance that Sandipan was sufficiently hydrated to provide a sample, which could be important, and would have allowed more time for Sandipan to be observed and monitor his clinical condition for signs of improvement or deterioration.[83]

77. However, Mr and Mrs Dhar were finding it difficult to obtain a urine sample from their son. Mr Dhar explained that his wife tried to breastfeed Sandipan to bring on urination, but she was not producing much milk as she had not had anything to eat or drink and was very anxious. They asked for some juice from more than one staff member, but it was never brought to them, and ultimately they could not get Sandipan to produce a urine sample. Dr O'Hearrain recalled at some stage he was approached by Sandipan's parents. They explained Sandipan hadn't provided a urine sample yet and asked whether they could go home and take the sample there? Dr O'Hearrain wasn't sure so he told Mr and Mrs Dhar he would need to speak to Dr Siow.[84]

78. Dr Siow had been busy reviewing other patients but she had also had a brief conversation with the Dhars a bit earlier as she had walked past them near the fish tank opposite cubicle two. Dr Siow remembered that Sandipan had been watching the fish and had appeared interactive and not distressed at that time. She recalled Mr Dhar mentioned something about not having expected to be there in the ED, they had something they needed to attend to and had not eaten much that day. Mr Dhar

[80] T 258.
[81] T 152.
[82] Exhibit 1, Tab 12, p. 67 and Tab 23.
[83] T 259, 307 – 308.
[84] Exhibit 1, Tab 10.1.

was courteous but it was apparent they were querying the length of time they had been waiting and seeking clarification on how much longer they would need to wait. Dr Siow had got the impression they were getting a bit impatient, which is not uncommon for patients waiting for urine testing. Dr Siow had told Sandipan's parents that they were still waiting for the urine test and explained she really wanted the test to be undertaken that day. She recalled both parents nodded to acknowledge her advice. Dr Siow recalled it was only a brief interaction before she moved on to other patients.[85]

79. Therefore, when Dr O'Hearrain consulted Dr Siow after Mr and Mrs Dhar had asked him about going home, she already had some context. Dr Siow believed this conversation took place about 15 minutes before she took her dinner break at about 6.00 pm to 6.30 pm. Dr Siow recalled that Dr O'Hearrain asked her if he could discharge Sandipan because his parents were keen to go. Dr Siow asked if the urine test had been done and Dr O'Hearrain said it had not. Dr Siow responded that it was important they wait in the ED until the sample had been provided and she asked him to try to convince them to stay. Dr O'Hearrain returned to the cubicle and spoke to Mr and Mrs Dhar and relayed Dr Siow's response to them. He recalled that he said words to the effect, "We really should get this checked, just to see if there's anything in it."[86] His impression was that Sandipan's parents were agreeable to the advice that they should stay until the test was done.[87]

80. Dr O'Hearrain stated he did not think there were any language barriers that might have impacted on the parents' understanding of their discussion. Dr Siow had also not perceived any language barrier in her conversation with Sandipan's parents earlier.[88] Dr O'Hearrain's impression was that Mr and Mrs Dhar were very reasonable and very patient and he did not think they appeared hugely concerned at the time when he asked them to stay. He therefore expected they would comply and stay until the sample was obtained. Dr O'Hearrain gave evidence he did not recall either parent asking again for a blood test as part of that conversation.[89]

81. I note at this stage that Mr and Mrs Dhar's recollection does not align with the recollections of Dr Siow and Dr O'Hearrain, as they recalled that Mr Dhar asked Dr O'Hearrain, to get Dr Siow to come to them, and then they discussed the urine sample and also the possibility of a blood test. They recalled Dr Siow remained firm on her position that a blood test was not necessary but encouraged them to persevere with getting a urine sample.[90]

82. Nurse Rocchiccioli took another set of observations at 5.55 pm and later made an entry in the notes at 6.25 pm. His PARROT score from the second set of observations had dropped to 0 as Sandipan's heart rate had dropped now that he had settled and Nurse Roccchiccioli's impression was Sandipan's parents were no longer actively concerned. Nurse Rocchiccioli explained his usual practice was to ask the

[85] T 312 – 313.
[86] T 217.
[87] T 165 – 167, 182 – 183, 313 - 314; Exhibit 1, Tab 20 and Tab 22.
[88] T 245 – 246.
[89] T 166 – 167, 211; Exhibit 1, Tab 22.
[90] Exhibit 1, Tabs 10.1 [115] – [116] and 10.2 [6].

parents if there is anything they are worried about and if they don't bring anything to his attention, he will record the parental concern as 0, which he did here. If the parents had indicated they were unhappy with the treatment plan or felt their child was deteriorating, he said he would have recorded a 1, but he assumed given the score he entered that nothing was raised at the time. In terms of any cultural or linguistic barriers to this conversation, Nurse Rocchiccioli indicated his practice is generally to be "more inquisitive in my questioning with culturally and linguistically diverse people,"[91] but he had no particular recollection of his conversation on this occasion.[92]

83. Nurse Rocchiccioli recorded Sandipan's observations had "improved dramatically"[93] in the notes and he was now feeding well. It was also noted that they were awaiting the swab results and also urine analysis. It seems Nurse Rocchiccioli did not see the Dhar family again as he was then called away to two high priority cases.[94]

84. It is relevant to note that Sandipan's blood pressure was not taken on any of the three occasions when Sandipan's observations were taken that day, so in terms of the PARROT chart, the scores were not accurate as they did not capture all of the relevant information. This might have meant the observations were more reassuring than perhaps was warranted and could potentially have avoided consideration of sepsis. Dr O'Hearrain agreed in evidence that it was unusual for no blood pressure reading to have been taken and he also agreed it would be an important reading if a child were septic. However, he would have trusted the nurse would have tried their very best to take a reading, and it would seem they were unable to do so. Further, Dr O'Hearrain gave evidence Sandipan's fever itself was a prompt to consider sepsis, and after he checked and found "no signs of end organ damage, or a specific organ or part of the body being affected, which is usually what sepsis entails,"[95] he was not concerned that Sandipan might be septic at that time.[96]

85. Similarly, Nurse Rocchiccioli gave evidence clinicians are prompted to think of sepsis, even with quite mild symptoms. Sandipan's temperature reading in the waiting room (38.9°C) and his heart rate recorded at 4.30 pm (170 bpm), along with the fact the parental concern could be said to be continuing, all prompted a consideration of sepsis on the Sepsis Recognition Escalation Pathway.[97] However, Nurse Roccchiccioli's impression was that Sandipan did not look like a sick child and he was happy in any case that the patient was being seen by an RMO.[98]

BLOOD TEST

86. A significant issue in the inquest was whether blood testing should have been ordered on the first JHC presentation. In that context, Mr Dhar recalled requesting a

[91] T 121.
[92] T 121 – 123 Exhibit 1, Tab 12, p. 67, 75 and Tab 23.
[93] Exhibit 1, Tab 12, p. 70.
[94] T 111 – 112, 120 - 121; Exhibit 12, pp. 70, 75 and Tab 23.
[95] T 227.
[96] T 227.
[97] Exhibit 1, Tab 12, p. 75.
[98] T 109 – 110.

blood test be performed multiple times, including more than once to Dr Siow. In contrast, Dr Siow did not recall it being raised by Mr or Mrs Dhar, although she did recall independently considering whether a blood test was indicated.

87. No documentation was made in the medical records by Dr Siow herself, and there was also no record in the documentation written by Dr O'Hearrain that the case was discussed with Dr Siow or any other senior doctor, although it was noted that Dr Siow was the Consultant allocated on the paperwork. I understand this is common practice in an ED, and would have indicated to the relevant staff that Dr Siow was being consulted about Sandipan's care, although it does make it difficult at times to understand who was involved in decision-making without personally hearing from the doctors involved. We know now that Dr O'Hearrain discussed Sandipan's case with Dr Siow and Dr Siow personally examined Sandipan and advised on his management plan.

88. There is no reference to the blood test suggested by Dr Rana in the JHC documentation, nor why no blood testing was performed. There is evidence before me now from Dr O'Hearrain and Dr Siow that Dr Siow considered whether a blood test was appropriate and decided to wait until the other test results were received before deciding whether to take that next step. There are no details documented of any parental concern or request for a blood test, other than the initial score of 1 on the PARROT chart, although Sandipan's parents say they were very concerned. This is despite, Mr Dhar recalling he "requested several times (minimum 4 times) to have a blood test done but the duty doctors said that it wasn't required."[99]

89. Mr Dhar specifically recalled telling Nurse Rocchiccioli that they had come to the ED for a blood test.[100] Nurse Rocchiccioli gave evidence he "could not recall any particular urgency for a blood test or for any particular intervention"[101] when he spoke to Sandipan's parents. He indicated he would have written it down in the notes if it was an insistent or repeated request, but said he perhaps would not have noted it if the parents only asked for a blood test once, as it is not an unusual request. As noted above, he was aware the GP had mentioned a blood test in the referral letter and recalled mentioning it to Dr Siow, although he wasn't sure if he showed the letter to Dr Siow.[102]

90. As noted above, Dr O'Hearrain did recall Mr Dhar mentioning blood tests, in the context of their ED attendance and he also recalled it being mentioned in the referral letter that he read. In terms of the septic work-up or screen suggested by Dr Rana in the referral letter, Dr O'Hearrain observed that a urine test is much easier to arrange and would be done more commonly in the ED than a blood test on a child. Similar to the evidence of Dr Rana, Dr O'Hearrain gave evidence that taking blood from a paediatric patient like Sandipan has complexities because children typically find having blood taken a lot more distressing than adults and it may also be more difficult to access their veins. Dr O'Hearrain also noted that the suggestion of

[99] Exhibit 1, Tab 10 [31].
[100] T 446 – 447.
[101] T 115.
[102] T 115 – 116, 118 – 119.

IV antibiotics would have been dependent on the results of the blood and urine testing.[103]

91. Although Dr O'Hearrain could not recall whether he and Dr Siow specifically discussed performing blood testing, he believed it would have been an automatic consideration for a fever going for that long. Therefore, whether or not Dr Rana's suggestion (and Mr and Mrs Dhar's request) for a blood test was clearly communicated to Dr Siow, he believed it would already have been at the back of her mind due to the history and she would already be weighing up in her mind whether bloods were needed. Dr O'Hearrain gave evidence he recalled the general discussion was that Dr Siow didn't think doing bloods were indicated at that time, but instead suggested starting with a respiratory swab, a urine test and a drug to help with his sore throat so he could swallow, as well as encouraging oral fluids. Dr O'Hearrain had understood that depending on the results of those initial tests, Sandipan would then be reassessed and it was possible the consultant would have felt bloods were warranted at that time. However, at that initial stage, there had been no urgent need to do a blood test.[104]

92. Dr O'Hearrain also gave evidence his impression at the time was that Sandipan's parents had "seemed onboard"[105] with the plan. They had seemed very reasonable, pleasant and understanding and had not challenged the doctor's management plan, including the decision not to do a blood test at that stage.

93. Dr Siow gave evidence she had considered a haematological malignancy at the time she assessed Sandipan but she "thought it was very unlikely on that day."[106] Dr Siow explained that there was a clear source of fever from the inflamed tonsil, Sandipan looked really well and her understanding was he had not had a continuous fever for 20 days, all of which placed him quite low on the haematological side. Dr Siow gave evidence a blood test might be required if they were concerned Sandipan was "developing a secondary source of sepsis"[107] for his fever. However, weighed against those possibilities was the knowledge that "it is a traumatic experience for family and children in general"[108] as for a child of Sandipan's age, it will require the parent's help holding the child and will usually be done by putting a drip in and collecting the blood slowly from dripping out of the canula, which can take around half an hour. Dr Siow noted Sandipan looked well enough to wait and there was a clear source for the fever from the tonsillitis, which gave her some reassurance that it could be delayed while other investigations were done and then reconsidered. Therefore, she said that although she did give consideration for blood tests (namely a full blood count, urea, electrolytes, a CRP and blood cultures) to be taken, Dr Siow didn't think it would be beneficial at that early stage and she preferred to wait.[109]

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[103] T 140 – 144.
[104] T 144 – 146.
[105] T 146.
[106] T 250.
[107] T 252.
[108] T 252.
[109] T 252 – 253; Exhibit 1, Tab 20 [135] – [136].

94. Dr Siow said she shared her thought process with Sandipan's parents and explained it was probably going to turn out to be a viral illness so a blood test was not indicated. She formed the impression they were agreeable with her plan and the decision not to do a blood test at that point.[110] In that context, Dr Siow gave evidence she did not recall Sandipan's parents asking her to do a blood test, but rather she independently had thought about it as part of her consideration of an appropriate management plan. She explained she had thought it was borderline whether or not to do a blood test because the length of the fever still concerned her, even based upon an uninterrupted seven days prior to his attendance in the ED. She had chosen to order the urine test and PCR test and then intended to *follow them up closely* as the urine could potentially have shown a secondary source of infection in a different site. If the urine test had come back with no abnormalities, then Dr Siow gave evidence she had planned to ask the parents to bring Sandipan back to the ED the next day for another review, so she could monitor the clinical progression. However, this is inconsistent with the note made by Dr O'Hearrain in the management plan for a review on Wednesday and Mr and Mrs Dhar's recollection of Wednesday being mentioned for review, if needed.[111]

95. Dr Siow was asked if she recalled any discussion about Wednesday, and she responded that she did not think so. Dr Siow commented that Wednesday, being five days from the ED presentation, was "a very odd number."[112] She explained that typically she would ask someone to come back for review within 24 to 48 hours or frame it in more broad terms as 'early next week' or 'late next week', and it would be very unusual for her to state a specific day, such as 'Wednesday'. Dr Siow acknowledged the original course of antibiotics ran to Wednesday, but noted Sandipan was also on a new 10-day course and because she thought the source of the infection was viral, she was not expecting the antibiotics to be playing a part in any event. Dr Siow could not identify a reason why she might have stated they return for review on Wednesday, despite both Mr and Mrs Dhar and Dr O'Hearrain recalling Wednesday was mentioned. It was Dr Siow's evidence that she did not mention a follow-up plan at all at that early stage, and she only told Sandipan's parents that they were going to do the urine, viral PCR and COVID test and they should continue on the oral antibiotics regardless.[113]

96. Dr Siow gave evidence part of her decision-making depended on how the parents seemed to feel about it, and her impression at that time was that the parents were happy not to have the blood tests. She recalled Mr Dhar nodded and said something to the effect that they weren't expecting to be there in the ED that day, but the GP had asked them to come in. Based upon that discussion and their non-verbal cues, she thought they were accepting of her decision not to order immediate blood tests.[114]

97. Mr Dhar, on the other hand, made it very clear in his evidence that he recalled specifically asking Dr Siow for a blood test to be done and she denied the request

[110] T 251.
[111] T 254 – 257.
[112] T 255.
[113] T 255 – 257, 360.
[114] T 251, 253, 257.

and said it was not required. Instead, she told him that they would conduct a COVID test and PCR test for other viral illnesses, which indeed was done.[115]

98. Dr Siow could not recall Mr and Mrs Dhar doing or saying anything that gave her the impression they expressly wanted Sandipan to have a blood test. Dr Siow maintained if she had known the parents wanted a blood test then she would have discussed the pros and cons of doing the blood test at that time and given them the alternative of early review the next day. If, despite that discussion, Sandipan's parents had still been adamant they wanted a blood test performed, then she said it "would be an easy decision to just do it."[116] However, she did not recall any discussion about a blood test that night. Dr Siow gave evidence she did ask at the end of the consult if they had any questions and she recalled Sandipan's parents did not have any at the time.[117]

99. Dr Siow was also asked at the inquest about whether she considered ordering a chest x-ray, and she responded that she did not think a chest x-ray was necessary at that time, mainly because Sandipan didn't show any sign of increased work of breathing. His initial examination by Dr O'Hearrain had also found that his chest was clear and there was no cough, at least in the ED.[118]

100. I understand from Dr Siow's responses in questioning that she considered Dr O'Hearrain a competent junior doctor she could trust at the time, although in hindsight she felt that there was some information in the GP letter that should have been relayed to her but was not. In that context, she agreed that, in hindsight, it would have been ideal for her to read the GP letter for herself. However, she also gave evidence that she does not think now that reading the letter would have changed her management on the night.[119] Dr Siow explained that having read Dr Rana's letter for herself, she appreciates he was seeking an opinion for a prolonged fever and she would interpret the request for blood tests, urine and plus/minus antibiotics as a request to exclude a secondary source of sepsis. Dr Siow gave evidence a blood test would not have changed the management of tonsillitis, nor Epstein-Barr (which was also mentioned in Dr Rana's letter as a differential diagnosis), but it would have been relevant to look for other signs of infection.[120]

101. Dr Siow was working on the assumption the diagnosis was viral tonsillitis and if the urine test had been negative, as it was likely to be, then this would not have prompted her to order a blood test as she would have continued to consider viral tonsillitis the most likely source of the fever.[121]

102. In hindsight, with the benefit of having read Dr Rana's letter, Dr Siow believes the only difference it might have made is that it would probably have prompted her to have a better discussion with Mr and Mrs Dhar, and specifically ask them about their

[115] T 447.
[116] T 258.
[117] T 258.
[118] T 308.
[119] T 335 – 336.
[120] 318.
[121] T 340 – 341.

expectation about what would happen in the ED. She also said she would probably have run through the pros and cons of a blood test. Dr Siow also believes that reading the letter would likely have led her to take notice of the mention of the scab on the thigh and at least have a look at it herself to make sure it was not an issue.[122]

103. Dr Siow also gave evidence that with the benefit of hindsight she would have reviewed Sandipan's PARROT chart for herself, which was her usual practice prior to a patient being discharged. However, having since read it for herself, Dr Siow did not think that reading the PARROT chart would have changed her management plan. Dr Siow noted his first temperature of 38.9°C when seen at triage was abnormal and his heart rate was slightly elevated at 152 bpm. His heart rate a little later, when taken by Nurse Rocchiccioli, was significantly elevated at 170 bpm but in the context of noted distress and after his temperature had dropped. His heart rate then also settled and dropped to 120 bpm. Dr Siow also noted he generally appeared interactive and alert and his perfusion was good, which was all quite reassuring. Although blood pressure readings were not taken, Dr Siow indicated this did not concern her in the context of these other reassuring features, and there was nothing in the readings to indicate possible sepsis at that time.[123]

104. Mr Dhar's evidence is that he and his wife had brought Sandipan to the JHC ED with the express hope of a blood test being performed. They provided the GP referral letter to the JHC staff, knowing it included a recommendation that a blood test be performed and they vocalised their desire for a blood test to be done more than once. Mr Dhar recalled that Dr Siow told him it wasn't required and he and his wife formed the impression at that time that she was "very determined not to have the blood test."[124] Mr Dhar gave evidence he did not want to raise his voice or argue with the doctor and he trusted her professionalism and integrity, so after asking three times for a blood test to be done, he accepted her medical advice that it was not required.[125]

Findings regarding family requests for a blood test

105. Dr Rana's evidence was consistent with Mr Dhar's evidence to the effect that Mr and Mrs Dhar had seemed very concerned and Mr Dhar expressly asked him to order a blood test on 22 March 2024. It was in that context that he referred Sandipan to JHC ED for a septic screen, which is set out clearly (from the point of view of a doctor) in the referral letter and included his belief that Sandipan would need a blood test.

106. Although Nurse Rocchiccioli did not recall any clear discussion about a blood test when he spoke to Sandipan's parents, he accepted it may have been mentioned once as part of taking the history.

[122] T 318 – 319.
[123] T 319 – 321.
[124] T 449.
[125] T 447 – 449.

107. Dr O'Hearrain did recall Mr Dhar mentioning the blood test in the context of the family being referred to the JHC ED and he also recalled Dr Rana mentioning a blood test in the referral letter in the context of performing a septic screen.

108. On the above evidence alone, Mr Dhar had repeatedly spoken to at least three clinicians about his desire (along with his wife) for Sandipan to undergo a blood test to try to investigate the cause of his prolonged fever and illness. He also placed reliance on the fact Dr Rana had included the recommendation for a blood test in the referral letter. Mr Dhar explained in a statement that he and his wife had "considered that a referral letter would demonstrate the importance of investigating the reasons for Sandipan's fever and would elevate the level of concern. [They] also believed that if the request for a blood test came from the GP, the doctors at the hospital would consider the request more seriously."[126] Having asked a number of people, in succession, for a blood test and knowing it had been included in the referral letter, it is understandable that Mr Dhar remembers vividly that he asked repeatedly for a blood test to be done. Therefore, I accept Mr Dhar's evidence that he repeatedly asked for Sandipan to undergo a blood test on 22 March 2024, not once but several times.

109. The main discrepancy is whether Mr Dhar repeatedly asked Dr Siow, personally, to perform a blood test, noting that Dr Siow did not recall the request being made directly to her by Sandipan's parents and she did not recall Dr O'Hearrain mentioning it to her when he summarised the contents of the referral letter. Rather, she recalled independently considering whether a blood test was required and then discussing the possibility with Mr and Mrs Dhar and explaining her reasoning for why she would not order a blood test at that stage.

110. It is difficult to resolve this difference in the evidence. I considered both Mr Dhar and Dr Siow to be honest witnesses, although accepting the reliability of their evidence was likely effected by the lapse of time and trauma. Unlike with Dr Rana, Dr O'Hearrain and Nurse Rocchiccioli, there was no written contemporaneous record of their thoughts or discussions at the relevant time, so all of their evidence comes from recalling after the fact.

111. In the end, I'm not able to resolve the conflict, but I'm not sure that as much turns upon it as was initially thought. That is because there is general agreement that Dr Siow did consider ordering blood tests and she explained she did not think it was required at that stage, although it was a finely balanced decision. Mr and Mrs Dhar would have expected that she had discussed the case with Dr O'Hearrain and they also expected she had read Dr Rana's letter at that time. Therefore, in their minds there were at least two other doctors who would have communicated to Dr Siow their desire for a blood test to be performed. When Dr Siow explained to them why she was not going to do a blood test, they would likely have understood her decision to have been made in that context. Mr Dhar indicated in his statement that neither he nor his wife challenged Dr Siow's management plan or her decision that Sandipan did not need a blood test at that time as they thought they would wait and try to press the issue later.[127]

[126] Exhibit 1, Tab 10.1 [82].
[127] Exhibit 1, Tab 10.1 [106].

112. Mr Dhar recalled that in a later conversation he mentioned again about a blood test, in the context of Sandipan not being able to provide a urine sample, although Dr Siow only recalled a brief conversation in passing about providing the urine sample, and a later conversation with Dr O'Hearrain in which she conveyed her desire for them to wait until the sample was provided again. Nevertheless, Dr Siow's general position was that a blood test wasn't required, so I infer that she was unlikely to have simply bowed to their request and would, as she indicated in her evidence, have been more likely to discuss the pros and cons with them if it had arisen.

113. I prefer Mr Dhar's evidence that he repeatedly sought blood tests across clinicians on 22 March. I am not able to find that he repeatedly made that request to Dr Siow, given the absence of a contemporaneous note and her contrary recollection. However, I am satisfied the issue of whether blood testing should be performed was considered by Dr Siow (either independently or prompted by parental request) and a decision was made that it was not necessary at that time after weighing up the pros and cons of doing so with a small child in the context of a likely diagnosis of viral tonsillitis.

URINE SAMPLE/TESTING

114. It was also identified that there was a divergence in the evidence as to what was the understanding about the importance of a urine test and how the Dhar family came to leave without the sample being provided.

115. It is not contested that a urine test was ordered by Dr Siow but a urine sample was not provided before Sandipan was taken home by his family on 22 March 2024. Sandipan's parents explained they had difficulty obtaining a sample and Nurse Rocchiccioli agreed it can be "challenging" to obtain one in the paediatric ED. He indicated nurses are aware of the need to seize any opportunity to obtain a clean catch sample but it is often the case that there can be long times waiting for the child to provide a urine sample. The task is usually left with the parents of the child, with some instruction from the nurses on how best to achieve it.[128] In this case, Sandipan's parents struggled to obtain a sample, which they thought might have been due to Sandipan being dehydrated, and they eventually felt they wanted to go home where he could be comfortable and feed properly.

116. There is a conflict in the evidence as to whether Mr and Mrs Dhar were encouraged to take Sandipan home and not to worry about providing the urine sample, or whether they decided to leave despite being encouraged by the doctors to stay until the sample had been provided and the test completed.

117. Dr Siow's evidence, which is supported by Dr O'Hearrain, is that she became aware that the family were asking if they could go home without the sample being provided, and she asked Dr O'Hearrain to encourage them to stay and provide the sample first.

[128] T 113 – 114.

118. The records indicate it was sometime between 6.00 pm and 7.00 pm that Sandipan left the ED with his parents and went home. There is no documentation recording why the family left the ED without waiting for the urine analysis and no indication of any consideration of follow-up to request them to return for that purpose. Although there was no formal discharge, the 'Time out of the ED' was recorded on the ED Medical Assessment Form as 7.03 pm. Dr Siow recalled she had spoken to Dr O'Hearrain just before going on her dinner break at between 6.00 pm and 6.30 pm and when she returned after 20 to 30 minutes, she noticed the cubicle where Sandipan had been waiting was empty.[129]

119. Mr Dhar indicated in his statement that they had been at the hospital for five to six hours by this stage and they had understandably begun to be concerned about the length of time that had elapsed with Sandipan having not eaten or drunk properly as he was still exclusively breastfed at that time and it seems his mother had not had an opportunity to eat or drink in the many hours they were there. They had struggled to obtain a urine sample as Sandipan had already urinated a couple of times before it was required. Possibly due to not feeding, he hadn't urinated again while they waited to obtain the sample.[130]

120. In his first statement Mr Dhar recalled they asked if they could take Sandipan home and take a jar with them to obtain a sample there. They indicated they would then return to the hospital the next day and bring the sample with them. Sandipan's father recalled the doctors told them that they did not need to take a urine sample container home and instead they should monitor him for a couple of days and bring him back to the hospital on Wednesday, 27 March 2024 (five days later) if he did not improve. They then took Sandipan home.[131]

121. In later evidence Mr Dhar recalled specifically they asked Dr Siow if they could be provided with a urine sample pot to take home with them and they would bring a urine sample back in the morning, but Dr Siow told them it was not necessary and there was nothing wrong with Sandipan. He recalled Dr Siow told them both that they could simply take Sandipan home and finish his antibiotics. If he was still sick on Wednesday, after his antibiotics course had finished, then they should bring him back then. Mr and Mrs Dhar were very upset but they understood that the doctors would not perform a blood test and they believed they were being told to go home and felt they had no choice but to go. They were also tired and hungry, so whilst they remained concerned about Sandipan, they trusted the advice of the medical staff and left.[132]

122. At the inquest, Mr Dhar also mentioned a number of conversations with Dr O'Hearrain and a nurse during which he and his wife felt that they were being told to leave the ED and go home, but they declined as they wanted to wait until a blood test had been performed, although they eventually resigned themselves to the fact it would not be done.[133]

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[129] T 314; Exhibit 1, Tab 20.
[130] T 361 – 363.
[131] Exhibit 1, Tab 10.
[132] T 449 – 450; Exhibit 1, Tab 10.1 [118] – [128] and Tab 10.2 [6].
[133] T 447.

123. Based upon the evidence before me, it is unclear who Mr and Mrs Dhar spoke to before leaving. Dr Siow did confirm in evidence that sometimes families are permitted to go home and obtain a urine sample, so nursing staff would have been aware it is sometimes allowed. However, she was firm that her consistent instructions were that she wanted the Dhar family to be encouraged to remain until the urine sample was provided. She denied having a conversation with Mr and Mrs Dhar in which she told them to go home and not worry about providing the urine sample.[134]

124. Dr Siow noted Mr Dhar in his first statement referred to some conversations with a consultant physician and/or a head nurse about going home, which was possibly a man. Dr Siow stated she always introduces herself as the 'senior doctor' but believed it was possible Mr Dhar spoke to another consultant while she was having her dinner break, or mistook a more junior doctor for a consultant – noting he referred in his statement to the "duty doctor and *his* full team".[135] However, Mr Dhar gave evidence at the inquest that he recalled speaking to Dr Siow that night and at the time he formed the mistaken impression Dr Siow was male, which was why he later referred to the senior doctor as 'he' in his first statement.[136] In his later statement he clarified that it was Dr Siow he was referring to when discussing these conversations.[137]

125. Nurse Rocchiccioli gave evidence that in the paediatric setting he would usually refer any request to go home before testing is completed to a doctor, so if the parents had spoken to him on the night and expressed their desire to go home before providing the urine sample, he would have consulted a doctor about their request. However, he did not recall speaking to Mr and Mrs Dhar before they left on this occasion and specifically did not recall Mr Dhar asking if they could collect a urine sample at home rather than waiting in the ED for one to be produced. Nurse Rocchiccioli indicated it is reasonably common that samples can be collected at home, but he would usually defer to the treating doctor's preference.[138]

126. Nurse Rocchiccioli gave evidence he had unfortunately lost track of the Dhar family towards the end of their stay, as he was caring for other patients, so he did not see the family leave. He was informed by another staff member that they had left the ED, which he did not find unusual as in his experience doctors will often personally discharge a patient so he didn't think much of it at the time.[139]

127. Dr O'Hearrain's evidence was to the effect he first became aware the Dhar family had left the ED when he saw Sandipan's bed space was empty. He asked a nurse because he thought it was possible they had just gone to the toilet, but the nurse advised Sandipan and his family had left the ED. Dr O'Hearrain was not aware if the parents had told anyone before they left, but he advised it is not unusual for parents to want to leave the ED, particularly if they have been there for a long period of time

[134] T 366, 370 – 372.
[135] Exhibit 1, Tab 20 [271] – [273].
[136] T 447.
[137] Exhibit 1, Tab 10.1.
[138] T 127; Exhibit 1, Tab 23.
[139] T 115 – 116, 118 – 119; Exhibit 1, Tab 23.

and it is also not unusual for parents to leave the ED with their child without telling anyone. Therefore, it seems he was not surprised and simply presumed Sandipan's parents had either had enough of waiting for Sandipan to provide the urine sample or else had to leave for another reason.[140]

128. Dr O'Hearrain stated ideally after a urine sample had been provided and analysed, Sandipan would have undergone a further medical review and his management plan would have been updated and explained to his parents, before he was formally discharged. However, once he became aware the family had left, he reviewed Sandipan's observation chart and saw that all of his vital signs had been within normal limits when they were last taken at 5.55 pm. In particular, he noted Nurse Roccchiccioli's indication that Sandipan's heart rate had settled to 120 beats per minute after his crying/distress had resolved. He also checked the integrated progress notes and saw that the PCR swab results were still pending and the urine analysis had not been done, but that Sandipan had settled, his observations had improved dramatically and he was feeding well. Dr O'Hearrain believes he then went and told Dr Siow that Sandipan had left and, in effect, they agreed it wasn't necessary to ring Mr and Mrs Dhar and ask them to bring Sandipan back. He believed Sandipan had shown positive signs of improvement and the parents had been appropriately safety netted. Dr O'Hearrain was aware Sandipan hadn't provided a urine sample and he thought he discussed that with Dr Siow as part of the conversation.[141]

129. Dr Siow recalled that when she returned from her dinner break, she immediately noticed the cubicle allocated to Sandipan was empty, so she asked Dr O'Hearrain where the family were. Dr O'Hearrain told her the family had left without informing any staff. Dr Siow confirmed this with other staff. Dr Siow gave evidence if she had been made aware that the family were intending to leave and she had been present in the ED at that time, she would have spoken to them personally to explore the reason why they wanted to leave and give them some alternatives. However, as she had been on her dinner break, this had not been possible.[142]

130. Dr Siow acknowledged the consultation was still "incomplete because they had not yet obtained a urine sample, which was critical to confirm or rule out a urinary tract infection. A urinary tract infection can lead to serious complications, including sepsis, which can develop rapidly."[143] Dr Siow stated that if she had known they were intending to leave before the test was finished, she would have advised them to return Sandipan to the ED for review the next day.[144]

131. However, based on Sandipan's presentation that day, Dr Siow gave evidence she was pretty comfortable with her diagnosis of viral tonsillitis and although she assumed they had not been given any discharge advice, she was aware the family were diligent in seeking medical care for Sandipan and believed they would bring him back if needed. From a practical sense, Dr Siow said there is not sufficient resourcing

[140] Exhibit 1, Tab 22.
[141] T 167 – 168; Exhibit 1, Tab 22.
[142] T 316.
[143] Exhibit 1, Tab 20 [224] – [225].
[144] Exhibit 1, Tab 20.

to follow up every patient who has left the ED before all tests are complete, so it is a judgment call in each case. If a test result came back that was abnormal and the patient had gone home, she would definitely ring them to let them know, but in this case she felt that Sandipan was well and his parents were reasonable and diligent, so she believed they did not require follow up at that time. This was despite the fact she was aware his urine had not been tested. Dr Siow commented that she had believed the urine result was probably going to be negative, in any event, and she also considered that the oral antibiotics he was already taking would be a protective factor against a bacterial infection.[145]

132. As Sandipan had left the ED, it was not possible for the discharge process to be fully completed. Nevertheless, it was standard practice to complete a discharge summary for any patient who attended the ED, so Dr O'Hearrain completed a discharge summary in order for it to be sent to Sandipan's GP. Dr O'Hearrain indicated a copy would ordinarily also have been given to Sandipan's parents, but they had already departed the hospital, so the summary would be sent to the GP only. The principal diagnosis was recorded as '*Viral Tonsillitis*' and under 'Treatment and Procedures Done' Dr O'Hearrain documented that Sandipan had been "given Panadol and Nurofen (sic) to good effect. Oral fluids encouraged. Resp PCR sent. Did not wait for UA [urine analysis]."[146] Under 'Discharge Instructions' it was documented:[147]

> *Safety netted – advised to re-present if symptoms persist by Wednesday. Advised to complete Abx [antibiotics] course. Oral fluids encouraged.*

133. Dr O'Hearrain was asked at the inquest why the discharge summary did not record that the family had left against medical advice, noting that it only recorded they had not waited for urine analysis, which we know referred to the failure to obtain a sample from Sandipan before they left. Dr O'Hearrain explained that Dr Siow had phrased her view to the effect that "ideally they should stay"[148] until the urine sample had been provided, rather than it being against medical advice for the family to leave without providing the sample. In his conversation with Dr Siow after he became aware they had left, neither of them held a high level of concern about Sandipan based upon what was known by that time, so he didn't think it warranted any further notation about their departure.[149]

134. Dr Siow gave evidence that when Dr O'Hearrain had asked her whether he should write discharge or discharge against medical advice, she had told him to just write discharge as they had left at their own risk, rather than having been discharged against medical advice (DAMA). Dr Siow explained at the inquest that she preferred not to write DAMA as there is always a risk of a negative connotation when people return to the ED, as there may be a perception they are non-compliant, so she only generally uses that term when she has had a discussion with a patient and given advice they should stay and they are adamant that they are going anyway. That was not the case with Mr and Mrs Dhar. Dr Siow saw Dr O'Hearrain writing in the

[145] T 314 – 317; Exhibit 1, Tab 20.
[146] Exhibit 1, Tab 12, p. 63 and Tab 22.
[147] Exhibit 1, Tab 12, p. 63 and Tab 22.
[148] T 171.
[149] T 171 – 172.

medical notes after their discussion but she said she did not read the entry he made.[150]

135. Reflecting back on these sad events, Dr O'Hearrain conceded in hindsight it might have been beneficial if he had checked in on the family again, just to see if they held any concerns or had any questions. If he had done so, he could have found out why they wanted to leave and encouraged them to stay. However, he only recalled the one conversation with the parents in which they discussed their desire to go home and he had thought at that time they were accepting of the need to stay until the urine sample was provided.[151]

136. In hindsight, it is also clear from Dr Siow's evidence that the fact Sandipan had not been able to produce a urine sample was concerning, in and of itself. Dr Siow explained that this was a factor in her wanting him to stay in the ED until a sample was produced. However, it is apparent that Mr and Mrs Dhar were not informed this was a concern.[152]

137. I note Dr Siow's evidence was that she had been planning to ask the Dhar family to return to the ED the next day for review if the urine test excluded a urinary tract infection. Dr Siow explained this was to ensure Sandipan could be closely monitored, given his prolonged fever, which she indicated in her statement could be a concern for sepsis if it did not settle,[153] and noting that since it was the weekend most GP practices might be closed or have no available appointments and they had already seen a GP on several occasions and then been referred to the ED.[154] She also gave evidence a fever of seven days' duration was a concern.[155]

138. However, when Dr Siow found out that the family had left before the urine test had been done and with no specific planned follow-up as far as she was aware, she did not ask a staff member to contact them, nor follow them up herself. In evidence, Dr Siow suggested this was because Sandipan had shown some improvement and she believed his parents were diligent and would bring him back of their own volition if he remained unwell or deteriorated, although she also agreed she was surprised they had left without first providing the urine sample.[156]

139. I find it difficult to reconcile these two positions; namely, on the one hand that Dr Siow was very concerned due to the prolonged fever and the risk it could become sepsis, so she would have asked Sandipan's parents to come back the next day even if the urine sample was negative, versus a decision that follow up was not necessary after finding out they had left. I accept Dr Siow did encourage Mr and Mrs Dhar to stay until the urine sample was provided, with the understanding that if it was positive it might require a change in the oral antibiotics prescribed and there was also a chance it could show a renal issue,[157] but there is nothing in the evidence before me

[150] T 317.
[151] T 173.
[152] T 326 – 327.
[153] Exhibit 1, Tab 2 [147].
[154] T 361; Exhibit 1, Tab 20.
[155] T 361.
[156] T 360 – 361, 366 – 367; Exhibit 1, Tab 20.
[157] T 308.

that supports the conclusion Dr Siow intended to closely follow up Sandipan by asking Mr and Mrs Dhar to bring him back to the ED the next day even if the urine test was clear. Dr Siow's behaviour after being informed that they had left without the sample being provided is inconsistent with this conclusion and, as I note below, is also inconsistent with my finding that the management plan was for Sandipan to return on Wednesday if he did not improve. However, I take into account that Dr Siow was told that Sandipan's observations and overall presentation had improved when taken prior to his departure.

140. Dr Siow agreed in evidence that with the benefit of hindsight the Dhar family should have been contacted after they left the hospital ED to discuss follow up and make a plan as to what should happen next. Dr Siow noted that since this time the ED has changed its practice to try to do this more consistently for all patients who leave the ED early. However, on this night it was not the usual practice and it is clear she was fairly sure Sandipan had viral tonsillitis that would resolve on its own and there was no secondary infection brewing.[158]

141. A secondary question that arises is whether, if the urine sample had been provided, would it have changed Sandipan's management plan? It is not in dispute that the urine sample would have tested negative, as we know now that Sandipan did not have a urinary tract infection. The question is whether a negative result may have prompted either more investigations at the time, or may have led Dr Siow to encourage Mr and Mrs Dhar to come back the next day, which may have changed the trajectory.

142. For the same reasons, I am satisfied that if the urine sample had been provided, it would not have changed the management plan by prompting either further investigations such as a blood test,[159] or a request to Mr and Mrs Dhar to return the next day. I am satisfied to a high degree of probability that if the urine sample had been provided, Sandipan would have been discharged as per the management plan entered by Dr O'Hearrain in the medical record, which I discuss further below.[160]

SAFETY NETTING - WEDNESDAY

143. As I have noted above, Dr Siow's evidence was to the effect she never discussed the family returning on Wednesday for review. Dr Siow gave evidence she had intended to ask the family to return to the ED the following day, if the urine sample tested negative for an infection or any other complication, as she was concerned that Sandipan had been experiencing fever for seven days.[161] However, when she found out the family had left without Sandipan providing a urine sample, Dr Siow did not think it was necessary to have them followed up and asked to return, either that night or the following day.

[158] T 376.
[159] T 340 – 341.
[160] Exhibit 1, Tab 12, p. 69.
[161] T 360.

144. Dr O'Hearrain's management plan written in the medical record on the night of 22 March 2024 specifically referred to Sandipan's parents being "Advised to re-present on Wednesday if symptoms persist."[162] Dr Siow did not make her own note in the record, so her recollection of events was not assisted by a contemporaneous note. Reflecting back, after being informed of Sandipan's sudden death, she could think of no reason why she would have suggested Wednesday,[163] but I note the evidence of Dr O'Hearrain was that the day was named by Dr Siow and he inferred at the time it was because the original course of oral antibiotics, which the plan also indicated the parents had been encouraged to continue, would have ended on Wednesday.[164] It was also in the context that it would be expected that Sandipan would start to improve within a couple of days if it was tonsillitis.[165]

145. Mr Dhar also distinctly recalled being told he didn't need to bring the urine sample back the next day and only needed to come back on Wednesday if Sandipan's condition did not improve.[166]

146. It is very difficult to ignore the contemporaneous record made by Dr O'Hearrain. Having heard Dr O'Hearrain's evidence about how he came to formulate the management plan in consultation with Dr Siow and reviewing the careful way he recorded the plan in the record, I am satisfied the only reason Dr O'Hearrain wrote the reference to Wednesday was because it was raised in discussion with Dr Siow, in the presence of Sandipan's parents, as part of the management plan. The management plan as written appears to have been predicated on what should occur if the urine test was clear, as was anticipated, and the only likely change was perhaps different antibiotics if the urine test was positive. In addition, when Dr O'Hearrain completed the discharge summary, it was after a further conversation with Dr Siow. In the discharge summary he again referred to the safety-netting done, including the advice to the parents to re-present if symptoms persisted by Wednesday and to complete the antibiotics course.[167]

147. In evidence at the inquest, Dr Siow said she had believed the urine result was probably going to be negative, in any event, and she also considered that the oral antibiotics he was already taking would be a protective factor against a bacterial infection. It was in that context that she had decided, when discussing how the discharge summary should be prepared, that it did not need to include a reference to the family leaving against medical advice.[168]

148. I accept the submission made on behalf of Mr and Mrs Dhar that it is improbable that Dr O'Hearrain and both parents misunderstood Dr Siow's plan about returning to the ED. I therefore find that the management plan was conveyed to Mr and Mrs Dhar as recorded contemporaneously shortly after the time of Dr Siow's review.

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[162] Exhibit 1, Tab 12, p. 69.
[163] T 255 – 256.
[164] T 150.
[165] T 253.
[166] Exhibit 1, Tab 10 [34].
[167] Exhibit 1, Tab 12, p. 63.
[168] T 314 – 317; Exhibit 1, Tab 20.

149. Where reliable contemporaneous documentation and aligned lay recollection coexist, I prefer them over an absence of recall, particularly for a discrete wording point. Accordingly, I am satisfied to a high degree of probability, that the reference to re-presenting on Wednesday recorded by Dr O'Hearrain came from Dr Siow, in the context where a urine sample was expected to be provided (and likely negative) and the working diagnosis was viral tonsillitis anticipated to resolve at home.

SANDIPAN'S RETURN HOME

150. After they left the ED, the Dhar family stopped to get some dinner as they had not eaten for many hours. They recalled Sandipan was eating and chatting with his brother. They then went home.[169]

151. Sandipan's nasal swab was subsequently positive for rhinovirus and Mr Dhar recalled he received a message of the test result after they had left. It did not suggest to him there was any need for him to return to the ED at that time. However, the JHC External Review Team identified that, "in retrospect, the diagnosis of viral illness did not explain the prolonged symptoms of intermittent fever, general unwellness and the failure of his immunisation site to heal."[170]

152. Nevertheless, Mr and Mrs Dhar had been led to believe there was nothing seriously wrong with their son at that time and there was no follow up from JHC ED staff asking them to return, so they simply continued to monitor him at home and give him analgesia as needed with an understanding they should return on Wednesday if he had not improved. I accept that Mr and Mrs Dhar's impression, following their attendance at JHC ED on Friday 22 March 2024 was that their son had a minor viral illness that would resolve on its own and they did not need to return to the hospital if his symptoms remained generally the same. Therefore, the fact that he continued to have a fever and was generally unwell quite understandably did not cause them any alarm at first.

153. On Saturday, 23 March 2024, Sandipan's parents recall the day passed uneventfully. They took Sandipan's temperature several times during the day and it went up and down between 37°C and 38°C. They recalled that when they had been at the hospital they had been told not to worry unless his temperature went over 38°C so they just continued to monitor him. He was playing and interacting as usual, so there was nothing else to raise their level of concern.[171]

154. On Sunday, 24 March 2024, Sandipan's parents noted a change in his condition. He was not comfortable to eat, although he was still breast feeding, and he was coughing. Mr Dhar gave evidence they were aware Sandipan was getting worse but they were still not too worried as they had been assured in the JHC ED that he wasn't seriously unwell. They thought perhaps he might be experiencing some side effects

[169] Exhibit 1, Tab 14.
[170] Exhibit 1, Tab 14, p, 11.
[171] Exhibit 1, Tab 10 and Tab 14.

from the antibiotics, but nothing that would raise their level of concern having been reassured at the hospital. [172]

155. However, Sandipan became progressively more unwell in the afternoon and it seems he may have vomited a number of times and was having trouble breathing. His parents became very concerned as he appeared to be deteriorating, so despite their misgivings, they took him back to the JHC ED at a time they remember as about 6.00 pm, although medical records indicate it was closer to 8.00 pm. Sandipan's father recalls that Sandipan was happy to get in the car and seemed okay during the car journey and when they first got to hospital, but then he rapidly deteriorated further.[173]

SECOND PRESENTATION TO JHC – 24 MARCH 2024

156. Sandipan presented to JHC ED just after 8.00 pm on 24 March 2024. He was seen for triage and allocated at Triage Code 2 (emergency) at 8.09 pm. He was in acute respiratory distress with extremely pale hands and feet and his conscious state was fluctuating at that time. Sandipan's father stated that he emphasised to the triage nurse that Sandipan had breathing difficulties, because he was aware that this would ensure his son was seen quickly.[174]

157. Junior Registrar Dr Taylor Harwood was working in the JHC Paediatric pod and he recalled that someone from triage rang through to the ED and advised that Sandipan needed to be seen as soon as possible. The senior registrar was busy attending to another urgent patient so Dr Harwood agreed to review Sandipan. Sandipan was admitted into the Paediatric pod and Dr Harwood saw him soon after at 8.15 pm in the presence of Sandipan's parents. Dr Harwood recognised immediately that Sandipan was very unwell and he quickly obtained some history from Sandipan's parents. In the course of providing the history, they advised that Sandipan had presented to JHC's ED two days' earlier and had been diagnosed with tonsillitis before being discharged home. They also described his current symptoms, including a temperature of 38°C at home, although it was within normal limits by that time, as well as reduced oral intake, intermittent drowsiness and vomiting, with an acute deterioration that afternoon.[175]

158. Dr Harwood then performed a physical examination, which found a number of features suggestive of likely sepsis, including increased work of breathing, pale peripheries, increased heart rate and mildly distended abdomen. Dr Harwood was unable to assess Sandipan's capillary refill time. Dr Harwood's impression, based upon the history, observations and physical assessment was that Sandipan likely had sepsis, potentially secondary to community-acquired pneumonia. A chest x-ray at 8.40 pm confirmed a right-sided pneumonia and his venous blood gas done at 8.42 pm was significantly abnormal. Dr Harwood was very concerned for Sandipan, so he called the senior registrar to assist with his care. Intravenous access was

[172] Exhibit 1, Tab 3 and Tab 10.
[173] Exhibit 1, Tab 3 and Tab 10.
[174] Exhibit 1, Tab 12, p. 26 and Tab 14.
[175] Exhibit 1, Tab 21.

obtained and blood tests, including blood cultures, were taken. Sandipan was administered IV fluids and antibiotics, the first line of treatment for sepsis, soon after.[176]

159. At 8.50 pm Sandipan became very distressed and required increased oxygen. He then experienced reduced consciousness and became floppy. A Medical Emergency Team (MET) call was activated at 9.08 pm. ED Consultant Dr Valerie Astle, who also has specialist training in paediatric emergency medicine, took over the resuscitation efforts and all attempts were made to save Sandipan's life. Perth Children's Hospital doctors were consulted and they gave suggestions to assist the resuscitation attempts, but sadly all attempts were futile. During the resuscitation, staff were informed that Sandipan's platelet count was extremely low (8) and he had blast cells on his blood film, consistent with leukaemia. Sandipan was given repeated doses of adrenaline as part of aggressive resuscitation efforts, but after he did not provide a response, all resuscitation efforts were ceased and his death was declared by a doctor at 10.38 pm.[177]

160. Based upon the preliminary results of blood testing performed that night Sandipan's treating physicians felt he had suffered overwhelming sepsis (septic shock) on the background of likely undiagnosed leukaemia. The sepsis had led to multiorgan failure. This information was provided to the WA Police when Dr Harwood notified them of Sandipan's death that night, not long before midnight.[178]

161. Sandipan's parents accept that the doctors and nurses on this night did everything they could to save Sandipan on 24 March 2024, but sadly it was too late.[179]

CAUSE AND MANNER OF DEATH

162. Following receipt of an objection to an autopsy being conducted, an external examination and post-mortem CT scans were undertaken at the State Mortuary by Forensic Pathologist Dr Kirralee Patton. These examinations showed a young male child who appeared well nourished. The CT scan showed opacification of the lungs, with the left lung completely dense and airless and the right lung with only a small volume of aerated lung. There was also hepatomegaly (an enlarged liver) and splenomegaly (an enlarged spleen). There was no sign of significant injury.[180]

163. Dr Patton also reviewed the medical notes from the GP medical centre and from his admission to JHC. Dr Patton noted the history of immunisations, possible diagnosis of tonsillitis leading ultimately to Sandipan's presentation to JHC ED on the evening of 24 March 2024 after he appeared to be struggling to breathe and after he vomited. He quickly deteriorated at the hospital and was diagnosed with septic shock from an unknown infection. He then suffered a cardiac arrest and after approximately 45 minutes of CPR, resuscitative efforts were ceased.[181]

[176] Exhibit 1, Tab 12 and Tab 21.
[177] Exhibit 1, Tab 12 and Tab 21.
[178] Exhibit 1, Tab 4.
[179] Exhibit 1, Tab 10.
[180] Exhibit 1, Tab 8.
[181] Exhibit 1, Tab 8.

164. Dr Patton observed that during resuscitation on 24 March 2024, blood tests were taken, which later showed it was highly likely that Sandipan had undiagnosed leukaemia. This would have rendered him unable to fight infection. These tests also showed that Sandipan had suffered multiple organ failure and was likely to also have had disseminated intravascular coagulation, which is a condition that affects the blood's ability to clot and stop bleeding. All of this was likely associated with the sepsis. A chest x-ray showed changes of inflammation and pneumonia in the right lung and a respiratory tract swab collected on his first presentation to Joondalup Health Campus on 22 March 2024 detected the presence of rhinovirus (the common cold virus). The presence of rhinovirus was later confirmed by virology testing as part of the postmortem examination. No other respiratory viruses were detected.[182]

165. Microbiology testing only found a bacterium that was likely the result of contamination of the blood cultures, rather than being relevant to Sandipan's death. That is consistent with no bacteria being grown from cultures collected at the hospital on the night of his death, although noting Sandipan was on antibiotics at the time.[183]

166. Toxicology analysis showed the presence of an antihistamine medication, ibuprofen and paracetamol, all medications used to treat his symptoms prior to his last hospital presentation. Medications in keeping with the resuscitation attempts at Joondalup Health Campus were also detected. Nothing that might have caused or contributed to the death was noted in the toxicological findings.[184]

167. Immunophenotyping identified a population of B lymphoblasts (37% of cells) in the peripheral blood. Dr Patton explained in her report that this is most consistent with acute B-lineage lymphoblastic leukaemia. Acute lymphoblastic leukaemia (ALL) is a type of blood cancer of the white blood cells (lymphocytes). It originates in the bone marrow, which is where new blood cells are made. ALL usually develops quickly over days or weeks. Unfortunately, many of the symptoms of ALL are vague and non-specific. The symptoms of ALL are also similar to the symptoms of many minor childhood illnesses.[185]

168. Based on the information provided, the findings of the post mortem examination and ancillary studies, Dr Patton determined it appeared "Sandipan suffered a fatal cardiorespiratory arrest on a background of sepsis, secondary to pneumonia and undiagnosed acute lymphoblastic leukaemia."[186] Dr Patton formed the opinion the cause of death was complications of acute lymphoblastic leukaemia and Dr Patton also expressed the opinion the death was due to natural causes.[187]

[182] Exhibit 1, Tab 8.
[183] Exhibit 1, Tab 8, Tab 12, Pathology Report, p. 1 of 4, and Tab 13.
[184] Exhibit 1, Tab 8 and Tab 9.
[185] Exhibit 1, Tab 8.
[186] Exhibit 1, Tab 8, p. 2.
[187] Exhibit 1, Tab 8.

169. I accept and adopt the opinion of Dr Patton as to the cause and manner of death. I find that Sandipan died from complications of acute lymphoblastic leukaemia and his death was due to natural causes.[188]

ACUTE LYMPHOBLASTIC LEUKAEMIA (ALL)

170. As noted above, Acute Lymphoblastic Leukaemia (ALL) is a type of blood cancer. It affects immature lymphocytes developing in the bone marrow. Under normal conditions, these cells grow and mature into specialised white cells called B-lymphocytes (B-cells) and T-lymphocytes (T-cells). When ALL is present, these cells undergo a malignant (cancerous) change and multiply in an uncontrolled way, interfering with normal blood cell production. Excess numbers of these abnormal lymphocytes (known as lymphoblasts, leukaemic blasts or leukaemic cells) spill out of the bone marrow and into the child's bloodstream. A haematologist or laboratory professional identifying these blasts in a blood sample should raise a concern of ALL and generally will lead to urgent further investigations.

171. Childhood cancer is extremely rare. Leukaemia is the most common type of cancer among children, although still rare. In Australia in 2022, 332 children between 0-4 years received this diagnosis, which represents 0.02% of this specific population in Australia. A GP, for example, is likely to encounter a child with cancer only once every 20 years.[189] I understand the incidence of ALL is highest in children between the ages of two and four and it is more common in boys. There is no known cause of ALL although there are some general risk factors, such as genetic factors and exposure to radiation. If diagnosed in time, almost all children treated for ALL will achieve a remission from their disease and most will be cured.

172. However, the early presentation of paediatric leukaemia, with non-specific symptoms often mimicking the common, self-limiting illnesses, complicates the diagnostic challenge faced by front-line clinicians. The number of medical reviews that can occur before an acute leukaemia is diagnosed in a young child < 2 years can vary considerably as children in this age group often present with non-specific findings and it is only in the presence of findings such as excessive bruising, petechiae, mucosal bleeding, marked pallor or hepatosplenomegaly where clinical suspicion of a leukaemic process is often raised. Therefore, it is said to be common for children to have several consultations with healthcare providers before the diagnosis of leukaemia is made. Importantly, it is often parents noticing their child is 'just not right' and a change in health seeking behaviour that may be an early indicator for concern.[190]

173. The review by the Paediatric Oncologist and Clinical Haematologist as part of the JHC Root Cause Analysis agreed that none of the most common features of ALL were documented to be present by either the GP, Dr Rana or the RMO, or recalled by the ED Consultant Dr Siow at interview for the SAC 1 investigation.[191]

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[188] Exhibit 1, Tab 8.
[189] Exhibit 1, Tab 13 and Tab 14.
[190] Exhibit 1, Tab 13, p. 9 and Tab 14.
[191] Exhibit 1, Tab 13.

174. However, it was also noted during the Root Cause Analysis that in the majority of cases, performing a full blood count is able to identify an underlying leukaemic process and a full blood count would have had a very high probability of revealing a diagnosis of leukaemia if it had been performed on Sandipan on 22 March 2024. Identification of leukaemia would have significantly changed the management as Sandipan would have been immediately transferred to the Department of Clinical Haematology and Oncology at PCH. Generally speaking, a child with ALL could be expected to have a good survival outcome with definitive treatment.[192]

175. In Sandipan's case, the Consultant Paediatric Oncologist & Clinical Haematologist considered that a retrospective review of the clinical history and course indicated that it is likely his leukaemia would have started to develop prior to his presentation to the ED on 22 March 2024 and that if a full blood count had been performed on that date, it would have been grossly abnormal. As such, he would have been immediately transferred to PCH for appropriate supportive care and definitive treatment and he would have been likely to have had a good survival outcome.[193]

176. Whilst it was felt the documentation did not show any features to specifically suggest a diagnosis of leukaemia at the initial presentation, and on that basis the care was considered appropriate, the Consultant Paediatric Oncologist & Clinical Haematologist did suggest as an area for consideration would be as to whether there should have been persistence with regard to documentation of a blood pressure, whether a three week history of intermittent fevers which had not responded to oral antibiotics should raise concerns for further investigation and from a departmental level, the policy for consideration of blood tests when specified on the referral letter by the GP.[194]

ROOT CAUSE ANALYSIS (SAC 1 Clinical Review)

177. I note at the time the Root Cause Analysis/SAC 1 investigation was completed the cause of death was not available, which hindered the investigation. In any event, there are restrictions under the *Coroners Act* as to what information can be provided to clinicians for the purposes of this kind of internal investigation without the consent of the next of kin. There are obvious challenges in obtaining consent from grieving families. It is hoped that there may be legislative change in the future that will permit the Coroners Court to facilitate the exchange of this kind of information in appropriate circumstances, such as for a SAC 1 investigation, but for now it is sufficient to say that the understanding of the likely cause of death was accurate, even at an early stage, so it does not appear to have impacted upon the validity of the findings of the root cause analysis.

178. Sandipan's death had been quickly identified by senior JHC staff as a matter requiring investigation. It was deemed a SAC (Severity Assessment Code) 1 event (which essentially reflected that it was clinical incident where death or permanent

[192] Exhibit 1, Tab 13.
[193] Exhibit 1, Tab 13.
[194] Exhibit 1, Tab 13.

harm was not reasonably expected as an outcome of health care). As a result, an internal investigation was conducted under the North Metropolitan Health Service framework. The investigation team included an Emergency Consultant and a Consultant in Paediatrics, an ED Clinical Nurse Specialist and a Risk Officer, along with appropriately qualified independent specialists in ED management and paediatrics, as well as a Paediatric Oncologist & Clinical Haematologist. The focus of the review was on system failures in order to improve patient safety.[195]

179. The panel reviewed both the first and second presentation. Some interviews were conducted with staff involved in the events and the medical record was considered within the context of the relevant policies. Some information was also provided by Sandipan's parents for context. Understandably, any trust Mr and Mrs Dar had held in the opinion of the medical professionals who saw their son in the weeks leading up to his death, and particularly on 22 March 2024, has been lost. Having done what any responsible and caring parent should do and taken their child to see, not one but several, doctors when they were worried that their normally healthy son was inexplicably unwell, they can't understand how no one identified that he was suffering from an identifiable and potentially treatable disease. Nevertheless, they engaged with the process in good faith.[196]

180. In relation to the first presentation, the panel noted the isolated tachycardia of 170 bpm on the second set of observations on the PARROT chart was concerning and "is recognised as sensitive for sepsis/significant illness."[197] However, the clinicians also considered this in the context of a distressed child and the reassurance provided when the tachycardia improved on a later reading as his temperature returned to normal. It was also noted the reading was in the context of no blood pressure readings being taken due to the child being distressed. The panel felt reasonable attempts had been made to take the blood pressure readings and they considered the lack of a reading had not impacted the outcome. The panel also agreed that a clear improvement in Sandipan's clinical condition was reflected by the noted improvement in observations and nursing assessment.[198]

181. The issue of whether a blood test should have been performed was considered by the panel, noting the GP letter and information provided by Mr and Mrs Dhar to the effect they had asked for blood testing on at least three occasions. However, in contrast none of the JHC staff interviewed recalled the parents requesting bloods and believed the ED Consultant raised the topic of blood tests independently. Key staff were reinterviewed and the family's recollections were put to them, to ensure due diligence. The panel noted the staff showed genuine surprise at the contrasting recollections but the JHC staff remained steadfast in their own recollections of events. They acknowledged that in future a good practice might be to use more direct questions to explore parental concern, given the potential this case highlighted for misinterpretation.[199]

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[195] Exhibit 1, Tab 13.
[196] Exhibit 1, Tab 10.
[197] Exhibit 1, Tab 13, p. 7.
[198] Exhibit 1, Tab 13.
[199] Exhibit 1, Tab 13.

182. The panel also acknowledged there was evidence before them that revealed parents who were extremely concerned for their child and had sought medical review for him on at least two occasions prior to presenting to JHC. There was an apparent disconnect between this evident family concern and the perceived parental concern by the clinicians. The panel believed this "may have been influenced by cultural factors in how concern was externalised but not specifically by language barriers."[200] The investigation team acknowledged that "the current tool to measure parental concern, a binary score indicating concern is present or absent, has limitations, especially in parents who may not be as overt with their requests or concerns due to cultural or other factors."[201] It was noted that this is a mandated state wide tool and beyond the control of JHC to change but the panel recommended JHC consider implementing an additional tool to assess parental concern, which could encompass cultural safety and include a guideline for escalation of concerns. It was proposed this should occur as part of a wider review of the paediatric ED systems and process, with a particular emphasis on "empowering staff to be receptive and responsive to parental concern,"[202] which was supported by Sandipan's family and the clinicians involved in this case. I will return to this issue later when I discuss culturally and linguistically diverse patients below.

183. It was noted in the Root Cause Analysis report provided to the Court that all the relevant actions from the thirty recommendations identified in the 'Independent Inquiry into PCH' that followed the death of Aishwarya Aswath have been implemented, including the CARE call.[203] The Root Cause Analysis had noted that at the time of both presentations to JHC, CARE call phones were located in the main ED wait room and the Paediatric ED wait room. Posters were also in situ, outlining the three steps to escalate worry/concerns. A CARE call was not made by Sandipan's parents.[204]

184. The investigation panel acknowledged that, with the power of hindsight, "there was a missed opportunity to complete blood tests"[205] on Sandipan on his first presentation to JHC. It was accepted these tests "would have likely identified ALL and given the opportunity for transfer for tertiary specialist care for further investigation, supportive management and definitive treatment for his leukaemia."[206] However, the RCA panel and the Paediatric Oncologist & Clinical Haematologist consulted as part of the review agreed that with the information available to them at the relevant time, the care provided on both presentations was appropriate and well managed and, in particular, there was nothing to specifically suggest Sandipan had an underlying leukaemia when he presented to JHC ED on 22 March 2024. On that basis, the panel concluded the decision not to complete blood tests was appropriate.[207]

[200] Exhibit 1, Tab 13, p. 8.
[201] Exhibit 1, Tab 13, p. 8.
[202] Exhibit 1, Tab 13, p. 9.
[203] Exhibit 1, Tab 13.
[204] Exhibit 1, Tab 13, p. 14.
[205] Exhibit 1, Tab 13, p. 15.
[206] Exhibit 1, Tab 13, p. 15.
[207] Exhibit 1, Tab 13, p. 15.

185. However, the panel also acknowledged that "a possible misinterpretation of parental concern may have influenced the clinical decision to not take bloods"[208] although it was difficult to conclude if this was causative.

186. In reaching these conclusions, the panel acknowledged the immense grief of Sandipan's family and apologised for the additional trauma the investigation process appeared to have caused them. "They wanted to make it clear the findings do not dismiss their concerns or recollections and has highlighted the need to explore the area of parental concern in more detail."[209] Given the clear difference in recollection between Mr Dhar and Dr Siow, in particular, it was recommended that an external independent review of the paediatric ED services be undertaken with a focus on the robustness of ascertaining, recording and responding to parental concerns and wishes.[210]

187. The panel also recommended that in the event a family leave the ED with their child before a comprehensive discharge discussion has taken place, then the discharge summary should be sent to the family. Further, it was recommended that JHC consider the development of a proforma text message that can be forwarded to families in the event that communication is required post discharge from the ED.[211]

JHC EXTERNAL REVIEW – DR BELL & DR BRAGANZA

188. Dr Shahina Braganza is an Emergency Physician and Dr Christa Bell is an Emergency Physician and Paediatrician. They both practise at Gold Coast Hospital and Health Service in Queensland. Dr Braganza and Dr Bell were engaged by Ramsay Health Care JHC as part of a multidisciplinary Independent External Review Team to review the care provided at JHC to Sandipan and another child who also attended JHC's Paediatric Emergency Department in 2024. This review arose from the Root Cause Analysis report into Sandipan's death and a similar recommendation from the Root Cause Analysis investigation into the 'near miss' event involving the other child. Importantly, both cases involved circumstances where there was asserted to have been a high level of parental concern that was not recognised by the treating clinicians. The Terms of Reference for the review identified the purpose was to provide an independent exploration of the care and support provided to Sandipan and the other paediatric patient, to review any changes to care processes made since that time, and to recommend further enhancements to Paediatric Emergency Department services at JHC (noting a SAC 1 clinical review had already been conducted into both cases).[212]

189. The Terms of Reference identified the qualifications for membership of the review team, which is set out below, along with the participants:[213]

[208] Exhibit 1, Tab 13, p. 15.
[209] Exhibit 1, Tab 13, p. 15.
[210] Exhibit 1, Tab 13, pp. 15 - 16.
[211] Exhibit 1, Tab 13, p. 16.
[212] Exhibit 1, Tab 14.
[213] Exhibit 1, Tab 14.

a. Independent Emergency Physician and Paediatrician (Dr Bell);

b. Independent Emergency Physician (Dr Braganza);

c. Independent Emergency and Paediatric Intensive Care Nurse & Nurse Educator (Nurse Nott);

d. Consumer Representative (Mr Anderson, WA Police Veteran and father with lived experience of children with ALL and member of CAHS Community Advisory Group); and

e. Cultural Representative (Prof Jaya Dantas, Dean International and Professor of International Health at Curtin University and member of the Indian community).

190. The Review Team met with Sandipan's parents as part of the review process, in order to hear the family's story, to understand their experience and also to discuss the review process and their expectations. It was acknowledged that Sandipan's parents were unable to reconcile the healthcare approach and decision-making by clinicians with their own strongly held sense of concern and advocacy for their son. The mother of the other child, who was also consulted, similarly expressed concern at the failure of the clinicians to recognise a potentially life-threatening diagnosis in the context of an informed parent expressing her concerns.[214]

191. The Review Team also met with several hospital staff, both clinicians and administrators, as part of the process. It was noted in the report that "[h]ospital clinicians are typically knowledgeable, skilled and experienced but are often challenged by working in demanding and hyperdynamic contexts comprising crowded physical environment, complex patient and illness factors, and heavy cognitive load including supervision burden."[215]

192. Dr Braganza facilitated and coordinated the conversations with other members of the Review Team and led the framework/structure of the final report. The final report was co-authored by both Dr Braganza and Dr Bell and the recommendations included at the end of the report were team-based.[216] While the entire report was included in the documentary evidence before me, the focus of the oral evidence given by Dr Braganza and Dr Bell was understandably on the care provided to Sandipan, although the recommendations encompassed lessons learned from both cases.

193. In the Executive Summary of the report, it was observed that ALL is a challenging diagnosis to make, especially during a discreet ED presentation. Typical features include pallor, fever, anorexia and lethargy, but these features are also typical of far more common and less sinister diagnoses, such as viral illness. "Indicators to the diagnosis rely on sequential assessment over a period of time and can be facilitated by careful interval reviews. Indicators can also be given by those who know the child well, such as the parents,"[217] which emphasises the importance of listening carefully

[214] Exhibit 1, Tab 14.
[215] Exhibit 1, Tab 14, p. 3.
[216] T 261; Exhibit 1, Tab 14.
[217] Exhibit 1, Tab 14, p. 3.

to parental concerns, as well as conducting thorough assessments that reveal these subtle clues.

194. The Review Team identified:[218]

> *the clear key theme that arose upon review of both cases was the recognition and response to parental concern. This vital aspect of clinical care requires effective communication by skilled clinicians and hospital teams working in systems that facilitate this: listening to the consumer voice, the confidence to challenge one's own diagnostic reasoning and responding in a manner that enables informed and shared decision-making between clinician and consumer.*

195. Importantly, the Review Team acknowledged that, "Addressing parental concern is a universal challenge within healthcare services, particularly in EDs."[219] They advocate for improvements in how parents can express and escalate concern, and how clinicians can respond to this concern.

196. It was also noted in the Final Report that whilst children often experience delays in cancer diagnoses, these delays "are exacerbated for children within other priority population groups, including [*relevant to this case*] … children from diverse backgrounds."[220]

197. Further, whilst childhood cancer is rare, the overall incidence rate is increasing, so it is important that our healthcare systems evolve to maximise opportunities for early diagnosis. One of those ways may be to implement systems which highlight repeat presentations or changes in health-seeking behaviours, which was a feature in Sandipan's case.[221]

198. In the Final Report, it was noted that a recent systematic review sought to identify features of leukaemia to aid clinicians in detecting this diagnosis sooner. The study found over 50% of children with leukaemia have palpable livers, palpable spleens, pallor, fever or bruising on diagnosis.[222]

199. Fever in children is a common reason to attend an ED, accounting for around 20% of all visits, and the majority of these children will have a self-limiting viral respiratory tract infection and will get better within five days. Prolonged fever is more significant, but even then it is noted that some viral illnesses can occur in clusters, which is why it is important to distinguish between one persistent/prolonged febrile illness and several intermittent illnesses with periods of recovery. Even in prolonged fever cases, the Review Team noted that a recent prospective observational study of 35,705 children presented to EDs with fever found 10% of children had a fever lasting five days or more and cancer was the cause in less than 0.1% of all cases,

[218] Exhibit 1, Tab 14. P. 4.
[219] Exhibit 1, Tab 14, p. 4.
[220] Exhibit 1, Tab 14, p. 10.
[221] Exhibit 1, Tab 14, p. 10.
[222] Exhibit 1, Tab 14, p. 12.

with around 71% of the prolonged fever cases having an upper or lower respiratory tract infection.[223]

200. I note Dr Patton found evidence of hepatomegaly (an enlarged liver) and splenomegaly (an enlarged spleen) during the post-mortem examination. However, Dr Rana, Dr O'Hearrain and Dr Siow all said they found the abdominal examination to be unremarkable and they did not detect any organomegaly. Sandipan was noted to have abdominal fullness on his final presentation not JHC, so at least at that time clinicians were able to detect it. Dr Bell had discussed this feature with the forensic pathologist and clinical radiologist, Dr Fiona Bettenay, and in their opinion the level of enlargement at the time of death would suggest that the enlargement of the spleen and liver was sufficient to be palpable on the Friday night first presentation. Dr Bettenay commented that the degree of hepatosplenomegaly, in particular, was significant and in her experience would have taken some time to develop (a week or weeks rather than days).[224] However, it was noted by the Review Team that hepatosplenomegaly is a difficult clinical sign to detect in small children even when clearly present, as detection requires a relaxed and reclined child. Gross organomegaly can also be mistaken for abdominal wall tensing.[225]

201. In hindsight, other subtle features of ALL may have also been present when Sandipan was reviewed by the various GPs and Dr O'Hearrain and Dr Siow. These include possible pallor (a sign of anaemia), a black spot noticed by at least his father on his palate although not by any of the doctors who reviewed him, the persistent mark at the immunisation site and his leg pain that had led to the first GP assessment. It was noted by the Review Team that it was unclear from the documentation whether there was dialogue about pallor during Sandipan's first ED presentation, although the general evidence is that it was considered at least by Dr Siow, and she did not see evidence of pallor. It was suggested that the detection of pallor may have influenced the threshold for a blood test, but it was acknowledged that assessing pallor in all children can be challenging, and particularly so in darker skinned children.[226]

202. My understanding during the inquest was that it was not in dispute that a blood test would have provided an opportunity for a diagnosis of ALL to be made before Sandipan became critically unwell, if it had been performed at the first ED presentation. I understand from the submissions filed on behalf of JHC that potentially this is now in dispute. To the extent that this is not accepted, I indicate that I am satisfied on the evidence before me that the suite of blood testing that would likely have been performed on 22 March 2024 if ordered by Dr Siow (full blood count, venous blood gas, urea/electrolytes/creatinine, inflammatory markers and blood cultures) would have revealed abnormalities that would very likely have prompted further investigations and the diagnosis of ALL would have been made.

203. However, the reviewers agreed with the Root Cause Analysis findings that a blood test alone is not a reason to refer a child to an ED, and decisions to perform blood

[223] Exhibit 1, Tab 14, p. 12.
[224] T 298; Exhibit 1, Tab 9.
[225] T 298 – 299; Exhibit 1, Tab 8 and Tab 14.
[226] Exhibit 1, Tab 14.

tests or indeed any tests in the ED are based on the likelihood that they will alter management. Other factors include prevalence of disease, an alternative explanation for symptoms, prior experience of disease diagnosis and the logistics of conducting the test. Weighed against these factors is the recognition that 'something' has tipped the GP's threshold to want to further investigate, and the reviewers agreed that the "concerns of the referring clinician should be taken as an additional data point in the process of diagnostic reasoning."[227] The Review Team also observed that referral for additional testing creates an expectation for patients and families, which should be considered, explicitly explored and the rationale for decisions clearly communicated and documented, ideally including what may alter this decision. It was noted that at times, parental reassurance is a reasonable indication to conduct a test, but this needs to be balanced with the safety and logistics of doing so.[228]

204. The Review Team acknowledged that one of the biggest unresolved frustrations for Sandipan's parents is around their request for blood testing, which they felt they had expressed clearly, and was supported by the GP letter they had presented to the ED staff. The reviewers acknowledged there is a disconnect between the family and the ED staff on this topic.

205. Dr Bell and Dr Braganza agreed in evidence that the pattern of illness-seeking behaviour of Sandipan's parents, re-presenting multiple times to GPs and then referred on to the ED, was an important feature in this case. However, Dr Bell also observed that it would not be unusual to see a child with a respiratory illness progress from repeat GP attendances to an ED presentation as the illness progressed, so it would not necessarily raise alarm for clinicians. Nevertheless, Dr Bell agreed that "this is an illness pattern of behaviour that ideally our systems should be able to recognise and talk to each other in."[229]

206. For Sandipan's family, the GP letter also represented a 'black and white' directive that the actions suggested (a blood test, urine test and consideration of IV antibiotics) needed to be undertaken, without the need for further review by the ED staff. The ED staff understood their role was to undertake their own assessment, including a taking of relevant history and direct examination, which included the GP letter but was not determined by the terms of the letter.[230]

207. Dr Bell agreed in evidence that the referral by the GP Dr Rana with a suggestion for a blood test was important and it would have been ideal for the JHC doctors to articulate to Mr and Mrs Dhar why a different decision was being made, particularly given the family expectations. Ideally, Dr Bell suggested it should be documented and, as a minimum, the rationale should be discussed and explained with the 'home care team', in this case the parents. However, it seems at least Dr Siow was unaware that Mr and Mrs Dhar were relying upon the referral letter to ensure a blood test was done, and further, Dr Siow believed she did discuss adequately the possibility of a blood test and why she was choosing not to go down that route at that time.[231]

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[227] Exhibit 1, Tab 14, p. 14.
[228] Exhibit 1, Tab 14.
[229] T 271.
[230] Exhibit 1, Tab 14.
[231] T 270 – 272.

208. In that context, Dr Siow's evidence was that if she had realised Sandipan's parents expected, and indeed wanted, a blood test to be performed, it would have been an easy thing to do. However, she would still have gone through with them the pros and cons before making that decision and give them other options, such as an early review the next day.[232] The question then becomes why it was that Dr Siow did not realise that this was the family's wish or expectation; that is, what barriers were there to good communication between Sandipan's parents and the JHC nurses and doctors?

209. There was a gap in communication that led to disconnect between the Dhar family and the ED staff around the discharge phase and the likely timeframe for review. Mr and Mrs Dhar understood that the planned disposition was discharge and review in five days/Wednesday if symptoms persisted, which was consistent with the reference to Wednesday in the management plan. It was suggested by the Review Team that safety netting could have been discussed earlier in the consultation, and ideally would have provided information about expected illness trajectory and red flags to prompt earlier return. Dr Bell in evidence observed that safety netting is a really important component of paediatric emergency care as the majority of children who present to an ED will go home, and a small proportion of those children will have illnesses which may change quite rapidly.[233] Therefore, early safety netting conversation can maximise the opportunity to "start to paint a picture of what we're worried about and what would change our trajectory."[234]

210. The Review Team commented that Sandipan would likely have been discharged from ED that evening regardless of whether a blood count, blood gas or a blood culture, was performed.[235] However, that is not my understanding of the overall evidence about the abnormalities that blood testing (particularly a blood gas) would have shown.[236] If the suggestion is that those results might have taken time, and the family may have been sent home before the results came in, then I would assume that there would have been appropriate follow up with the family on the Saturday once the results were seen (barring the blood culture, which would take time and likely wouldn't have shown anything concerning).

211. Overall, the Review Team clinicians concluded that the assessment and management of Sandipan at his first ED presentation at JHC was "consistent with a reasonable standard of care i.e. faced with a similar isolated ED presentation in any mixed ED, the clinical decisions made would be considered to lie within an acceptable range of care."[237]

212. The JHC EXTERNAL REVIEW also made a number of recommendations, which have been supported by JHC. In relation to the recommendation about parental awareness of escalation pathways, JHC's ED patient information booklet has been reviewed and patients can receive an electronic version. The CARE Call posters in

[232] T 258.
[233] T 276 – 277; Exhibit 1, Tab 14, p. 14.
[234] T 277.
[235] Exhibit 1, Tab 14, p. 15.
[236] T 401.
[237] Exhibit 1, Tab 14, p. 20.

use at JHC have also been enhanced and are on display in all cubicles in the ED. The CARE Call phone has also been changed to pink to improve visibility, noting Sandipan's parents don't recall seeing any of this information on the night.[238]

EXPERT REVIEW - PROFESSOR LAWTON

213. At the request of solicitors acting for the Dhar family, Associate Professor Luke Lawton (Professor Lawton) also conducted an independent medical review of the care provided to Sandipan by the GPs at Key Largo Medical Centre and at JHC ED on his first and second presentation. Professor Lawton is a Fellow of the Australasian College for Emergency Medicine (ACEM) and an Associate Professor at James Cook University College of Medicine and Dentistry. He currently works as a Senior Staff Specialist in Emergency Medicine at Townsville Hospital and was formerly the Director of Emergency Medicine at Townsville Hospital.[239]

214. Professor Lawton reviewed medical records and statements from the GPs, as well as the JHC medical records, the Root Cause Analysis and the report from the JHC External Review led by Dr Braganza and Dr Bell. Professor Lawton also had an opportunity to read Mr Dhar's statement accompanied by additional instructions provided by Mr Dhar to his solicitors. As a point of difference between the JHC External Review and Professor Lawton's review, Professor Lawton assumed Mr Dhar's instructions were accurate and the contents of his statement were true. Therefore, unlike the RCA panel and JHC External Review, Professor Lawton formed his opinion on the basis of *significantly expressed parental concern and a clear request for a blood test.*[240] I note, however, that even the other reviews had unequivocal evidence that Dr Rana had suggested a blood test in his referral letter, which was read by Dr O'Hearrain, although Dr Siow's evidence is she could not recall that being mentioned.

215. I found Professor Lawton's report and accompanying evidence of particular assistance in understanding the context of assessing a paediatric patient in an ED, in terms of how a clinician should ideally approach that task, as well as the many challenges that a clinician will face in forming a preliminary diagnosis and balancing what is the most likely diagnosis versus the risk of missing a significant diagnosis.

216. Professor Lawton observed as a starting point that a paediatric patient such as Sandipan, who was only 21 months old, cannot articulate individual symptoms. Therefore, third party history, which often comes from a patient's parents, is vital to obtain, with the caveat that the parents are generally not medically trained and may be unconsciously impacted by their own concerns or biases as to what is important. A period of observation to observe the progression or resolution of symptoms and the development of concomitant symptoms is also often necessary. "Thus the 'real world' assessment of a paediatric patient is complex and often is centred around historical and clinical findings."[241]

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[238] Exhibit 2.
[239] Exhibit 1, Tab 24.
[240] Exhibit 1, Tab 24, p. 14.
[241] Exhibit 1, Tab 24 [33].

217. Further, in forming his opinion, Professor Lawton adhered to the principle that for the competent practise of emergency medicine, formulating a differential diagnosis list requires two key questions to be answered:[242]

    1. *What cannot be missed?* This is centred around ensuring that diagnoses that may be life threatening if overlooked are appropriately excluded.

    2. *What is likely?* That is, determination of a diagnosis consistent with the symptoms articulated by a patient, their examination findings, and their results.

218. Following this line of reasoning, in assessing a febrile child with non-specific symptoms, Professor Lawton considered a number of key questions arise, with the primary basis to ensure that the possibility of sepsis is given due consideration:[243]

    a. Is there a readily apparent diagnosis, such as tonsillitis, otitis media or a urinary tract infection?

    b. Are there any signs of the child being 'toxic' or 'unwell', which might indicate the possibility of sepsis, or a need to perform investigations?

    c. Are there any patient specific factors (for example immunosuppression or an atypical course of symptoms) which require such a strategy to be modified?

219. Professor Lawton acknowledged that while in adults invasive investigations are often performed as a matter of routine, in children such a decision is more nuanced due to the pain and discomfort of performing some investigations, the possible risks of exposure to radiation and the fact that many children presenting to an ED will have self-limiting viral infections with no specific tests that assist with diagnosing them.[244] However, in his opinion assuming the least severe illness, rather than actively excluding the most serious through investigation, "is a very dangerous pathway of clinical reasoning."[245]

220. Professor Lawton observed that it is known that paediatric patients have a significant physiologic reserve that can result in a protracted detrimental state of compensated sepsis that may not be as clinically apparent as sepsis is in adults, which reinforces "the need for a significant degree of clinical suspicion when assessing a febrile child."[246] Professor Lawton also noted that bacterial sepsis may co-exist or complicate a viral infection and a large longitudinal study cited by the JHC EXTERNAL REVIEW showed that children with a fever of five days or more have an increased risk of serious bacterial infection, particularly pneumonia. The rise in pneumonia was thought to be due to secondary bacterial infection due to viral transformation of the respiratory biome. Therefore, in Professor Lawton's opinion, a longer duration of illness, or a transient recovery followed by recurrence of

[242] Exhibit 1, Tab 24 [36].
[243] Exhibit 1, Tab 24 [37] – [38].
[244] Exhibit 1, Tab 24 [35].
[245] Exhibit 1, Tab 24 [39].
[246] Exhibit 1, Tab 24 [40].

symptoms (as evidenced in Sandipan's case) "raises the spectre of serious bacterial infection as a complication of a viral infection."[247]

221. Professor Lawton offered no criticism of the care provided to Sandipan by the three GPs at Key Largo Medical Centre and I infer he considered their care of Sandipan to have been reasonable and within the scope of their general practice. I note Professor Lawton's comments that Dr Rana's referral letter articulated the crux of this matter very succinctly and his clinical reasoning was appropriate and should have been adopted in the ED.[248]

222. In relation to Sandipan's first presentation to JHC on 22 March 2024, Professor Lawton noted that generally a child presenting with an acute fever, no signs of toxicity and a reasonably clear diagnosis does not require further investigation, but rather can be managed with symptomatic treatment and a plan for review. However, Professor Lawton is of the opinion "that this paradigm did not apply to the diagnostic and clinical reasoning lenses which should have been used to assess [Sandipan] on 22 March 2024.[249] Professor Lawton observed that Sandipan presented with a history of three weeks of intermittent fevers, some signs of toxicity, and significant parental concern. He had also had two presentations to his GP, with enough concern being generated to refer him to the ED. In Professor Lawton's opinion, a reasonable practitioner faced with the information "should have formed a concern about the possibility of sepsis, or more occult diagnoses, and performed screening blood tests to evaluate for these possibilities."[250] In particular, Professor Lawton considered the 18 to 20 days of fevers, with perhaps at most a two day break, should have been investigated more thoroughly and it was inappropriate to treat the presentation as an acute fever in a non-toxic child.[251]

223. Professor Lawton observed that unexpected representation to an ED, or repeated healthcare presentations, are a red flag for serious or missed pathology from prior attendances. Although this was Sandipan's first presentation to an ED, it was on a background of repeated healthcare presentation to his GP, so this was in fact his third healthcare attendance. Professor Lawton expressed the opinion such a presentation should generally lead to an increase in the level of investigation undertaken, and a detailed review of the patient's symptoms to ascertain what may have been missed.[252] Professor Lawton also noted the elevated heart rate on two successive measurements, the fact he had diminished oral intake and had not passed urine (hence the issue doing the urine testing) and his overall distressed and grizzly state, were all relevant factors.

224. In contrast to the JHC EXTERNAL REVIEW Team's conclusion, Professor Lawton considered there was sufficient information available about the atypical nature of Sandipan's presentation for it to be recognised **prospectively**, at 22 March 2024, that the diagnosis of viral illness did not explain the prolonged symptoms of intermittent

[247] Exhibit 1, Tab 24 [48].
[248] Exhibit 1, Tab 24, p. 23.
[249] Exhibit 1, Tab 24 [51].
[250] Exhibit 1, Tab 24, p. 1.
[251] Exhibit 1, Tab 24.
[252] Exhibit 1, Tab 24 [52] – [54].

fever and generalised unwellness.[253] In his opinion, "there was a key cognitive error made, in that [Sandipan] was managed as if he were presenting with a fever of short duration in the setting of appearing clinically well, rather than recognising that in fact [Sandipan] had had a prolonged intermittent fever over a period of 20 days."[254] Professor Lawton observed that the suggestion of a 'clear resolution of fever' within the 20 day period was not well established, based upon the medical record, and was based solely upon some weak evidence that the parents had a recollection of him not recording a temperature for a short period. In any event, at most, it would seem there had been a resolution of symptoms for two days, which Professor Lawton did not consider to be sufficient to seriously pursue a hypothesis that there were separate, independent infections, with separate fevers that resolved in between bouts of infection.[255]

225. In Professor Lawton's opinion, "a reasonable practitioner should have reasoned that intermittent fevers for approximately 20 days represented a situation of more than just a normal acutely febrile child and raised the possibilities of:[256]

    a. Early bacterial sepsis complicating a prior viral infection.

    b. Atypical viral infection such as with Epstein Barr Virus.

    c. Inflammatory diseases.

    d. Kawasaki syndrome.

    e. Immune deficiency.

    f. Acute haematological malignancy:

    with the most realistic of these possibilities the first, namely sepsis or a serious bacterial infection.

226. Professor Lawton specifically noted in his report that he did not suggest that a reasonable medical practitioner should have suspected acute leukaemia at that early stage. Rather, he considered the question of reasonable management centred on whether there were reasonable grounds to investigate Sandipan for the possibility of sepsis and other serious diseases at the first presentation, rather than diagnose a simple viral illness and manage him expectantly.[257]

227. In Professor Lawton's opinion, there were significant concerning features in the presentation that should have prompted further investigation, primarily for the possibility of sepsis, namely:[258]

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[253] Exhibit 1, Tab 24 [56].
[254] Exhibit 1, Tab 24 [57].
[255] Exhibit 1, Tab 24 [58].
[256] Exhibit 1, Tab 24 [59] – [60].
[257] Exhibit 1, Tab 24 [62].
[258] Exhibit 1, Tab 24 [64].

a. intermittent fevers for 20 days;

b. several presentations to healthcare providers, and significant parental concern;

c. with respect to the WA sepsis pathway, he specifically met three high risk criteria: being re-presentation (including GP), parental concern, and being from a culturally and linguistically diverse background; and

d. tachycardia persisting despite resolution of fever, and no urine output in the ED for approximately five hours.

228. Given the above, and accepting there was significant parental concern (which I will come back to later) in Professor Lawton's opinion, a reasonable standard of practice would have been to investigate the child by:[259]

a. obtaining a urinalysis;

b. considering a chest x-ray;

c. taking pathology including:

i. Full blood count;

ii. Venous blood gas analysis;

iii. Urea, electrolytes and creatinine;

iv. Inflammatory markers; and

v. Blood cultures.

229. In Professor Lawton's opinion, there was considerable scope for blood test results to have changed the trajectory of Sandipan's care, as a raised lactate would mandate sepsis be considered and empirically treated, abnormalities in inflammatory markers or other physiological derangements (such as renal impairment) might have led to admission or further investigations, or blood film abnormalities might have led to a diagnosis of leukaemia. In essence, Professor Lawton thought it likely that any haematology tests performed would have been substantially similar to the full blood count collected two days later at his second ED presentation and therefore have shown acute leukaemia.[260]

230. Professor Lawton commented in his report that the line of reasoning articulated by Dr Rana in his referral letter aligns with the clinical reasoning he has set out in his report and, whilst the emergency department physician was responsible for making their own independent assessment of Sandipan, the GP referral letter placed a duty on the ED clinicians to assess the patient for themselves and decide whether they agreed or disagreed with his recommendation that certain diagnoses and investigations be considered. In Professor Lawton's opinion, it was unreasonable to

[259] Exhibit 1, Tab 24 [65].
[260] Exbibit 1, Tab 24 [67], [93] – [94].

disregard the GP's suggestion to perform blood tests, although I note the evidence of Dr Siow that she was unaware that this had been suggested, as she did not read the letter and did not recall the issue being raised with her.[261]

231. Professor Lawton also referred to an error in deciding to 'discharge' Sandipan on that date, as this had been inferred from the medical documents, although we now know Sandipan was taken home before formal discharge could occur.[262]

232. Returning to the issue of parental concern, Professor Lawton identified that parental concern is recognised as a flag or an indicator of possible sepsis in the sepsis pathways of a number of states, including Western Australia, and it should therefore be taken extremely seriously. Professor Lawton observed most parents are not doctors and may not be able to articulate their concerns in professional clinical terms, but significant parental concern should be taken as an indication to have a high index of suspicion for serious pathology.[263] However, I acknowledge that Professor Lawton has accepted as part of his assessment of the care in this case that significant parental concern was clearly present to the clinicians at JHC, whereas it is their evidence that they did not consider Sandipan's parents to be exhibiting significant levels of parental concern.

233. In reaching a conclusion about parental concern, I note Dr Rana's evidence that he considered they presented as concerned parents when he saw them on 22 March 2024 and Mr Dhar in particular openly expressed that he was still worried as Sandipan had been experiencing a fever for about three weeks and antibiotics hadn't worked; instead, he had now developed a runny nose and mild cough. In that context, and with his primary concern around the prolonged unexplained fever, Dr Rana recalled Mr Dhar and asked if they could do a blood test.[264]

234. Dr Rana indicated he would ordinarily have sent them to a general pathology service for that purpose, but in this case he knew Sandipan's parents were keen for him to have a blood test to try to identify why he had been experiencing prolonged fever, and he considered that this could most appropriately be done in hospital (particularly noting Sandipan was a small child and already irritable, so it would not be an easy task). Dr Rana also gave evidence that along with the blood test, he assumed other investigations might also be required to find the exact cause of the fever, and if Sandipan required intravenous antibiotics he would need to be admitted under a paediatrician. Therefore, Dr Rana wrote a referral letter to the Emergency Department doctors at Joondalup Health Campus and gave it to Sandipan's parents at the end of the appointment.[265] They took him straight to the ED that afternoon, as a demonstration of their level of concern. Nurse Rocchiccioli, who saw them first after triage, also noted they were concerned parents by the score of 1 he first allocated on the PARROT chart, which supports the conclusion they continued to appear as concerned parents to an objective observer on arrival at JHC. Nurse Rocchiccioli

[261] Exhibit 1, Tab 24, pp. 22 – 23.
[262] Exhibit 1, Tab 24, pp, 1, 18.
[263] Exhibit 1, Tab 24, pp. 23 – 24.
[264] T 74 – 75; Exhibit 1, Tab 10.
[265] T 78 – 83, 85 – 87; Exhibit 1, Tab 11 and Tab 15.

later downgraded that score when conducting further observations and the two doctors who spoke to Mr and Mrs Dhar formed a different view.

235. In summary, Professor Lawton considered that Sandipan's presentation on the first occasion was an unusual clinical picture and in his opinion there were grounds to be concerned that Sandipan may be presenting with sepsis, despite the fact he appeared reasonably well at that time. Professor Lawton commented that experience shows that sometimes children look very well and can then deteriorate rapidly, so there needs to be close attention paid to subtle signs that may indicate sepsis, which in this case was most significantly the prolonged fever. Professor Lawton observed that a fairly common pattern when it comes to paediatric sepsis is a viral infection that is complicated by a secondary invasive bacterial infection, and this should have been a consideration in this case.[266]

236. It seems this possibility of sepsis was in the back of Dr Siow's mind when she determined the decision to do a blood test or not was finely balanced. In Professor Lawton's opinion, if a senior colleague such as Dr Siow had consulted him about a similar case, he would have said "I think if you are questioning whether you should do blood tests in this case or not, ... the safer thing to do is to do them."[267] Although taking the sample might be unpleasant, it is a temporary unpleasantness, but if the blood tests are reassuring then we've crossed off the list a potentially serious diagnosis, and if this is sepsis, then doing blood tests will find it. Electing not to do the blood test would be taking a really serious risk in terms of progression of disease, if the diagnosis was missed.[268]

237. In relation to Dr Siow's plan to do a urine test first, and then consider whether a blood test might be indicated, Professor Lawton responded that urinalysis will diagnose a urinary tract infection, but it won't tell the clinician anything about the physiologic state of the child, particularly with regard to things like the lactate level, which is a marker of general infection. Therefore, although a urine test would be valuable to identify if a UTI was present, a full blood count and venous blood gas would also be important, in any event. In contrast to Dr Siow's statement that if the urine test was negative, she would not have done further testing at that time, Professor Lawton commented that if the urine is negative, he would still be wanting to do the blood test to check if there was secondary bacterial sepsis given the three week history of fever.[269]

238. Professor Lawton also agreed with Dr Siow's comments, based upon her learnings from this case, that it is always better for the senior physician to read the GP referral letter themselves, rather than relying upon a summary given by a more junior colleague. Professor Lawton commented than reading the letter himself, and also checking the recorded observations for himself, are important lessons he has learned over time and conveys to other practitioners. Professor Lawton suggested that asking for help from colleagues is also important when facing a diagnostic dilemma. In this case, there was an explanation for some of the presentation with a viral tonsillitis

[266] T 386, 396 – 403.
[267] T 386.
[268] T 386, 397 – 398.
[269] T 403 – 404.

diagnosis, but it was important to think about what else it could be, and where sepsis is in that mix of possibility, particularly with paediatrics, it is important to take the extra step.[270] Professor Lawton referred in his evidence to the NSW Health circular provided with his report that emphasises that heart rate is often one of the more subtle and underappreciated signs of sepsis in children, and in his experience he would have given greater weight to the increased heart rate readings, rather than attributing them solely to distress.[271]

239. Professor Lawton was also asked in questioning whether, putting to one side his assumption that parental concern was evident and Sandipan's parents had actively requested a blood test (as per the letter of instruction), he would still take the view that a blood test was indicated. Professor Lawton responded that if the family had not been asking specifically for a blood test, he believes he would have raised it with them and explained that, whilst uncomfortable, he believed blood testing was necessary. That is, in his opinion he would still have wanted to perform blood testing at that time, even without prompting from Sandipan's parents.[272]

240. In Professor Lawton's view, when Dr Siow reviewed Sandipan and considered whether to order blood tests, a reasonable practitioner would have suspected a material risk of illness beyond viral tonsillitis given the prolonged (even if intermittent) fever and the presence of tachycardia at around 4:30 pm, despite the temperature having reduced. Recognising that viral illness may be complicated by bacterial infection and that young children can compensate physiologically before deteriorating rapidly,[273] he would have ordered blood tests at that time to help exclude sepsis. He maintained that opinion even on the assumption that significant parental concern was not apparent beyond repeated GP presentations and without any request for blood tests by the parents. Because his opinion was that bloods should have been taken then, he did not focus on the later period when the family had left without a urine sample and Sandipan's observations had improved; when asked hypothetically, he said he would not have telephoned the family to request their immediate return.

GP CARE REVIEW - DR SIMON YOUNG

241. Dr Simon Young is a Fellow of the Royal Australian College of General Practitioners and also has a Fellowship from the Australian College of Psychological Medicine. He worked as a partner in a private GP practice from 1987 to 2020 and is now semi-retired, working as a locum GP. Dr Young also was a former lecturer at Sydney University in the Departments of General Practice and Paediatrics and Child Health.[274]

242. In order to provide an expert report in this case at the request of counsel for Dr Rana, Dr Young reviewed the medical records from the Key Largo GP practice, along with

[270] T 386 – 389.
[271] T 390; Exhibit 1, Tab 24, Appendix 8: NSW CEC Circular.
[272] T 405.
[273] T 419
[274] Exhibit 1, Tab 16.

the JHC ED medical records and Dr Rana's statement, as well as some other documents.[275]

243. In his written report prepared for the inquest, Dr Young observed that "[t]here is a threshold above which disease is easy to recognise and diagnose, and below which it can be impossible to diagnose because of a paucity (or conversely complexity) of history, signs and symptoms."[276] The challenge for a GP is dealing with this uncertainty, where definitive diagnosis is not always possible, and a safe doctor will use time and review to aide diagnosis and safety net, providing continuity of care.

244. Having reviewed the relevant materials in this case, Dr Young expressed the opinion that overall Dr Rana's clinical records are of a high standard, bar some typographical, spelling and syntax errors, and they were more than sufficient to facilitate continuity of patient care. In Dr Young's opinion, Dr Rana's provisional diagnosis on 20 March 2024 that Sandipan had bacterial tonsillitis, hence a trial of oral antibiotics with early follow up was consistent with commonplace GP practice. When Sandipan's parents brought him back, as requested, two days' later, Dr Rana noted new symptoms of a cough and runny nose and also appropriately recorded that these were 'concerned parents'; implicit in this statement is a recognition that 'parents know their children best'.[277] In Dr Young's opinion, Dr Rana's decision, with parental input, to then send/refer Sandipan to ED was "both safe and clinically apposite."[278] His referral letter was comprehensive and in Dr Young's opinion, Dr Rana's indication referral was made clear in the entry "He would need bloods, Urine +/- IVABs."[279] Further, Dr Young suggested that implicit in any GP's suggestion that a patient needs intravenous antibiotics is that they are unwell enough to be admitted.[280]

245. Overall, Dr Young expressed the opinion Dr Rana's treatment of Sandipan was consistent with competent professional GP practice. It is clear Dr Rana was dealing with an uncertain, evolving diagnosis of tonsillitis with a puzzling fever history on 20 March 2024. By 22 March 2024, Dr Rana was moving away from a tonsillitis diagnosis and was considering other diagnoses, and he was sufficiently concerned to consider a septic screen might be necessary, which led to referral to an ED for workup and management.[281]

COMMENTS OR FINDINGS ON MEDICAL CARE

GP Care

246. Dr Young's opinion was not challenged at the inquest, and I note Professor Lawton's report supported Dr Young's opinion that Dr Rana acted appropriately in referring Sandipan to an ED with a detailed letter of referral. Accordingly, I make no adverse

[275] Exhibit 1, Tab 16.
[276] Exhibit 1, Tab 16 [11].
[277] Exhibit 1, Tab 16 [37] – [38].
[278] Exhibit 1, Tab 16 [39].
[279] Exhibit 1, Tab 16 [43].
[280] Exhibit 1, Tab 16 [44].
[281] Exhibit 1, Tab 16 [46] – [58].

findings or comments in relation to any of the GP care provided in this case. Further, I wish to add my comment that Dr Rana appears to have been diligent in his care of Sandipan. He appropriately arranged early follow up after the first consultation and responded proactively to the obvious parental concern at the second consultation by providing a detailed referral letter for Mr and Mrs Dhar to take with them to the hospital. In hindsight, if his sensible suggestion for consideration of a sepsis screen had been followed, the outcome may have been different in this case.

Was it reasonable not to order a blood test on 22 March 2024?

247. I have set out in considerable detail the various findings of the panel involved in the SAC 1/Root Cause Analysis, the JHC EXTERNAL REVIEW and Professor Lawton's review as it is important to understand the detailed nature of the reviews and the differences in what evidence or propositions, they accepted in reaching their conclusions.

248. It was submitted on behalf of JHC that for the purpose of this inquest, the question I have posed above can really only be that qualified, experienced and competent experts disagreed, so no finding can be made. I am inclined to agree with this submission. However, I have set out below the limited comments I feel I am able to make, acknowledging the expertise of all of the reviewers and the acceptance of the proposition that reasonable minds will differ.

249. Putting to one side the fact that the reviews were sourced by different clients, which even with the best of intentions may sometimes have some impact upon the outcome due to the access that can be gained to information from one side or the other, the primary differences between the conclusions of the JHC EXTERNAL REVIEW panel and Professor Lawton hinge on:

    a. the issue of the presence or absence of parental concern and repeated requests for a blood test; and

    b. whether we are considering the appropriateness of ordering a blood test at the time Dr Siow reviewed Sandipan when only the observations taken at 3.05 pm and 4.30 pm were available, or later in the night after all of the information was available, including the reassuring observations taken at 5.55 pm.

250. All of the experts agreed that there was nothing to specifically suggest that Sandipan had an underlying leukaemia on 22 March 2024 that should have suggested blood testing was required. I understand the experts also agreed that viral tonsillitis provided an explanation for the source of the infection causing at least most of the symptoms. The difference seems to be whether there was sufficient uncertainty about this diagnosis explaining his prolonged fever (whether it was 20 days uninterrupted or with a two day break) to be able to rule out a possible secondary source of infection and developing sepsis?

251. Professor Lawton considered there was a key cognitive error made at 4.40 pm that Sandipan was presenting with a fever of short duration, which was consistent with viral tonsillitis, rather than recognising his persistent, even if intermittent, fever for a period of 20 days. Professor Lawton also pointed to the tachycardia (raised heart

rate) persisting despite resolution of his fever at 4.30 pm. Together, they were possible signs that a serious bacterial infection might be present as a complication of a viral infection. Professor Lawton referred to the risk of a life-threatening outcome if the diagnosis is missed, weighed against the limited trauma of obtaining blood samples from a small child, and expressed the opinion a reasonable and diligent practitioner faced with what was known at 4.40 pm would have ordered pathology testing.[282] Professor Lawton agreed in evidence that the decision whether to do a blood test in this case was finely balanced, but with the benefit of his 20 years' or more experience he tends "to err on the side of the investigation rather than not."[283] Professor Lawton expressed the opinion reasonable care required investigation for the possibility of sepsis and other serious diseases on 22 March 2024 and in his opinion pathology testing should have been performed. However, I also note that Professor Lawton expressed his opinion as to what the majority of his peers would do with an acceptance that significant parental concern was known to Dr Siow, which is not the agreed position by all of the experts who reviewed this case, and was a matter of contention in the inquest.[284]

252. Dr Bell and Dr Braganza, on the other hand concluded (consistent with the conclusions of the SAC 1 investigation team) that Dr Siow's finely balanced decision not to order blood testing was consistent with a reasonable standard of care in the context of an isolated ED presentation in a mixed ED (so not a specialist tertiary children's hospital), based upon the presentation that suggested viral tonsillitis as the source of the fever. Although the elevated heart rate at 4.30 pm was concerning, it was explained by Sandipan's distressed state, and this was reinforced later by observations taken at 5.55 pm, which painted a more reassuring picture than the observations taken at 4.30 pm.[285]

253. As I have indicated above, I do not consider I am able to resolve the differences between the opinions of the experts, all of whom are eminently qualified to express an opinion on this issue, but whom also have considered the matter from different perspectives and have acknowledged that the decision was finely balanced. As it was quite properly put in submissions on behalf of Dr Siow, "there is a spectrum of what constitutes reasonable care"[286] and in that context, there is more than one view amongst properly qualified experts as to what constituted reasonable care in this case, and I am not in a position to choose between them based upon the evidence currently before me.

Failure to appropriately safety net/recall the Dhar family to the ED

254. JHC submitted the most important issue arising from this inquest relates to the question of safety netting and why Sandipan's parents were not contacted if Sandipan's parents took him home before the treatment plan was carried out? Dr Braganza and Dr Bell agreed that, ideally, it would have been prudent to have

[282] Exhibit 1, Tab 24.
[283] T 387.
[284] Exhibit 1, Tab 24 [63], [105].
[285] Exhibit 1, Tab 14, p. 20.
[286] Submissions filed on behalf of Dr Yii Siow, dated 31 July 2025, [54].

rung Sandipan's parents and requested them to come back before Wednesday (noting that this was the safety netting documented by Dr O'Hearrain in the management plan and later in the discharge summary). However, they also acknowledged that it can be difficult in a busy ED such as the JHC ED.[287]

255. JHC pointed to the overall evidence that indicated Sandipan had significantly improved before he was taken home, and the assumption (although this may have been incorrect) that his parents were no longer excessively concerned for him as they had chosen to take him home. The Dhar family, on the other hand, point to the evidence that they had been advised to return to the hospital on Wednesday at an early stage, before any tests were even conducted, which would create an impression that they were going home that night regardless of what the tests might demonstrate and that there was nothing seriously wrong with their son.

256. I have already indicated above that I have accepted that Dr O'Hearrain's notation in the management plan to return for review on Wednesday reflected discussions with Dr Siow and Mr and Mrs Dhar. In my view, with that knowledge of what Mr and Mrs Dhar had been told as the safety netting, I agree with Dr Braganza and Dr Bell that best practice would have been for Dr Siow or Dr O'Hearrain to have attempted to call Sandipan's parents and ascertain why they had left and whether they were now comfortable that their son no longer required medical attention. I make this comment within the context of what was revealed by the examination of the other 'near miss' case considered in the JHC EXTERNAL REVIEW. In that case, after being unable to convince the treating doctors to properly consider her concerns about a snake bite, she took her child to a different hospital, where her concerns were proven correct. The difference between this case and that one is that in the other case, the parent was not willing to trust the doctors' advice, whereas unfortunately in this case Mr and Mrs Dhar placed more trust in the doctors' opinion.

257. If a phone call had been placed to Mr Dhar after he left the ED with Sandipan, it may have created an opportunity for Mr Dhar to explain their concerns about Sandipan and their disappointment that their expectation that a blood test would be performed had not been fulfilled.

258. I note that JHC ED has changed its practice somewhat since these two incidents, as a result of the lessons learned, and I discuss those changes further below.

Was Sandipan's death preventable?

259. Dr Siow expressly did not make any submission on whether Sandipan's death was preventable, if different treatment had been provided on 22 March 2024.

260. Sandipan's parents point to the report provided by the consultant paediatric oncologist and clinical haematologist as part of the SAC 1 investigation, which suggested that if blood tests had been performed on 22 March 2024 (as part of an investigation to exclude secondary sepsis), the results would have been grossly abnormal and likely led to a diagnosis of leukaemia. The haematologist also

[287] T 301.

expressed the view that Sandipan would have been likely to have a good survival outcome with definitive treatment. Therefore, it is submitted on behalf of the Dhar family that the evidence supports the conclusion that Sandipan would most likely have survived his illness had blood testing been performed on 22 March 2024, or certainly at least that there was a missed opportunity to diagnose and treat Sandipan (and potentially save his life) on 22 March 2024 if blood testing had been performed.

261. The submissions made on behalf of JHC highlight the complexity in this case due to Sandipan's underlying leukaemia but with a focus in the inquest on testing for sepsis on 22 March 2024 (given it was agreed that this was the more likely concern for a clinician at that time, rather than underlying haematological malignancy). Nevertheless, JHC submits there is no basis for me to find on the evidence before me that Sandipan's tragic death was preventable. The submissions point to the difference between Dr Bell and Professor Lawton's evidence about the likelihood that a blood gas (or a full blood count or other blood test results) would have shown an abnormality.

262. I rely upon the conclusions of JHC's SAC 1 review and noted the comments of the expert paediatric oncologist and clinical haematologist that "[i]n the majority of cases, performing a full blood count is able to identify an underlying leukaemic process and a full blood count would have a high probability of revealing a diagnosis of leukaemia if it had been performed on this child on 22 March 2024"[288] and acknowledging that "this would have been an incidental finding."[289] That is certainly what occurred two days later, when Sandipan re-presented to JHC ED, as noted by Professor Lawton,[290] and I take that into account in reaching my conclusion. Further, the expert expressed the opinion the identification of leukaemia would have significantly changed Sandipan's management as he would have been immediately transferred to PCH and, generally speaking, a child with ALL "could be expected to likely have a good survival outcome with definitive treatment."[291]

263. This was more than a missed opportunity. I find on the balance of probabilities that had blood tests been performed on 22 March 2024, Sandipan's leukaemia would have been identified, and he would likely have survived with definitive treatment; his death was therefore probably preventable. That conclusion sits alongside my earlier observation that whether to order bloods at the time was a finely balanced judgement on which reasonable practitioners may differ.

PARENTAL CONCERN AND COMMUNICATION

264. Despite advances in prevention and treatment of invasive bacterial infections, sepsis remains a leading case of childhood morbidity and mortality in Australia. The mortality rate for untreated septic shock is more than 80% in children, and even with treatment it is estimated the mortality rate is still in the range of 15-20%. In Australia

[288] Exhibit 1, Tab 13, p. 9.
[289] Exhibit 1, Tab 13, p. 9.
[290] Exhibit 1, Tab 24 [93].
[291] Exhibit 1, Tab 13, p. 9.

each year around 50 infants and children die as a result of sepsis and around 10 times more require admission to an Intensive Care Unit. As a result, there are various tools in place to try to identify these rare but serious cases, as the signs can often be missed or mistaken for other, less serious forms of illness.[292] That is sadly what occurred in this case.

265. There is no doubt that incidents with tragic outcomes, such as Sandipan's death, prompt reflection on how things can be done differently to ensure there is good communication between parents and clinicians so that both sides benefit from the knowledge of the other.

266. With the benefit of hindsight, Dr Siow referred in her statement to several things she would have done differently:[293]

    a. She would have read the GP's letter personally rather than relying on Dr O'Hearrain to distil the information in the letter. This might have alerted her to the fact the GP was concerned with a possible secondary source of sepsis, separate to the working diagnosis of tonsilitis. Dr Siow believes the content of the letter probably would not have changed her working diagnosis or management plan, but it contained information that both reinforced and supplemented the history Sandipan's parents provided and may have prompted her to ask Sandipan's parents why the GP thought a blood test might be necessary.

    b. She would have personally reviewed the PARROT chart to assess whether it contained additional information relevant to her assessment. Looking at Sandipan's PARROT chart in hindsight, Dr Siow noted there were two transiently abnormal observations, his temperature and heart rate. She does not believe her management plan would have changed based upon this information, however, it would have been ideal to have this additional information.

    c. Dr Siow would have considered using more direct questioning to explore Sandipan's parent's concerns, which may have elicited more information about their desire for Sandipan to have a blood test.

267. Dr Siow's evidence was that if she had been aware the Dhar's planned to leave the ED without Sandipan having the urine test, she also would have spoken to them herself to reassure them and reassess her concerns.

268. Once they left the ED, a decision was made by Dr Siow not to follow them up, but following the implementation of the recommendations of the JHC External Review the new JHC protocol for communicating discharge instructions after patients have left the ED would at least have involved a text message to Sandipan's parents after they had left the ED to communicate the discharge instructions.[294]

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[292] Exhibit 1, Tab 24, Appendix 8: NSW CEC Circular.
[293] Exhibit 1, Tab 20 [245] – [273].
[294] Exhibit 2.

269. When considering these statements overall, there is an underlying theme of communication with parents/care givers. This was flagged by the JHC External Review Team, who observed a common theme to both the cases they reviewed was that the parents did not feel their concerns were heard or addressed by JHC staff. It was noted that this is a common theme raised in critical clinical incidents. "Parental concern is widely accepted as a diagnostic contributor in patient assessment as evidenced by its inclusion in early warning scoring observation tools."[295] The WA Health mandated tool, the PARROT chart, like many other such tools uses a binary quantitative measure (0 = no concern, 1 = concern) which arguably diminishes its efficacy, particularly in a context of an ED presentation where, as Nurse Rocchiccioli noted, almost every parent will be concerned.[296]

270. The parents of both Sandipan and the other child considered in the review were not perceived by clinicians as overtly demonstrating concern, contrary to the expressed views of the parents. The mother in the 'near miss' case, indicated she took a measured, but persistent, approach so as not to alarm her daughter, and when she felt her concerns went unaddressed she made a deliberate decision to leave JHC ED and take her child to PCH. "Her ongoing concern is that other parents may have taken the discharge direction they were given, risking harm to their children."[297] Whilst Sandipan's case was prior to this other matter, it is relevant in the sense that Mr and Mrs Dhar were clearly reassured by the lack of urgency exhibited by the clinicians at the first presentation and the communication of the management plan that they understood to be telling them to come back on Wednesday for review. They perceived that they were, in effect, being directed to leave the ED once certain samples had been taken, which is similar to the experience of the mother of the other child. Mr Dhar explained to the reviewers that from the family's socio-cultural position, "doctors are infallible and are positioned 'in status just below God'. As such, he placed great trust in their expertise and judgment, and did not feel that it was appropriate to challenge this."[298] Having lost his son, he has also lost his faith in doctors' infallibility.

271. It was noted in the review, after consulting various staff at JHC, that "there is deeply sorrowful acknowledgment that a young family have lost their 21 month old son, [and] acknowledgment that enhanced communication and shared decision making may have increased the opportunity to detect subtle indicators of serious underlying illness."[299] The JHC External Review Team emphasised that communication failures between clinicians and families was the paramount factors in both cases they reviewed. "Both families described feeling disempowered in the decision making around their child's diagnosis and care. Both families felt unheard when they questioned diagnostic reasoning."[300]

[295] Exhibit 1, Tab 14, p. 14.
[296] Exhibit 1, Tab 14.
[297] Exhibit 1, Tab 14, p. 15.
[298] Exhibit 1, Tab 14, p. 15.
[299] Exhibit 1, Tab 14, p. 28.
[300] Exhibit 1, Tab 14, p. 30.

272. In the Final Report, it was emphasised that communication failure "results from multiple factors including structural, process-related and relational."[301] The recommendations made were intended to address these factors "in order to build the foundational elements for the provision of safe and high quality patient and family-centred care."[302] The Review Team observed that approximately 90% of paediatric patients are discharged from ED at JHC, which represents higher risk decision-making compared with when admitting a patient. Therefore, the Paediatric Pod medical care delivery may be enhanced by strategies that over time will ensure a greater proportion of specialists with additional training in paediatric emergency medicine working in the pod.[303]

273. The Dhar family submitted that all government run hospitals, including JHC and others, should introduce mandatory training for staff working in paediatric ED's or paediatric pods within ED's with respect to parental involvement in the decision making around their children's care, with a particular focus on parents knowing their children best . In addition, for clinicians to be encouraged to share their clinical reasoning with parents so they can make informed decisions around their children's care. The Dhar family submit such training should be developed with input from families affected by, in effect, SAC 1 events involving their children.

JHC CHANGES SINCE SANDIPAN'S DEATH

274. Dr Kevin Hartley is the Director of Medical Services (DMS) at JHC. Dr Hartley is a consultant anaesthetist by profession but he was not personally involved in Sandipan's care and his evidence at the inquest was limited to his role as DMS at JHC. Dr Hartley noted JHC's ED is one of the busiest in Western Australia, seeing a mix of adult and paediatric patients. The peak presentation time for paediatric patients occurs in the afternoon and evening. Some of the specialist consultant emergency medicine physicians who work in the ED have additional training in paediatric emergency medicine. Noting that Perth Children's Hospital has the only specialised paediatric ED in Western Australia, Dr Hartley advised that JHC is aiming, over time, to acquire a greater proportion of specialist consultant emergency medicine physicians who have additional training in paediatric emergency medicine. However, there is a shortage of physicians with these qualifications and many elect to work in specialist tertiary paediatric EDs, so it is not simply a case of JHC actively prioritising this kind of recruitment. In the meantime, Dr Hartley advised that the staff in JHC ED paediatric pod can request a member of the JHC inpatient paediatric department attend the ED and review any paediatric patient.[304]

275. Dr Hartley, on behalf of JHC, informed the Court that as a result of the SAC 1 investigation into Sandipan's death and the JHC External Review various changes have been made that impact on this issue.

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[301] Exhibit 1, Tab 14, p. 30.
[302] Exhibit 1, Tab 14, p. 30.
[303] Exhibit 1, Tab 14, p. 24.
[304] Exhibit 2.

276. The JHC External Review recommended JHC partner with consumers and enhance their approach to shared decision making with patients, parents and carers. JHC expressed a commitment to this philosophy and has undertaken work to fulfill the specific recommendations of the Review Team, including adding a consumer representative to JHC ED's consumer working party and the JHC Consumer Advisory Group provides ongoing consumer input. In addition, an ED consumer representative has been engaged to provide feedback and insights on proposed changes to the ED.[305]

277. Further, areas of improvement had been identified in utilisation of the CARE call, which can allow parents to express and escalate their concerns. Therefore, the changes have been put in place to make parents more aware of their options in this regard.[306]

278. Further, a new Paediatric Sepsis Pathway was rolled out in February 2025, and the new PARROT tool disseminated by the Child and Adolescent Health Service WA to JHC incorporates further guidance on assessing family concerns. The new PARROT tool includes an addition of New Confusion or Changing Behaviour, which is likely to prompt more discussion between clinicians and parents or caregivers to elicit that more subtle information. It also includes targeted and specific questioning to involve the family and elicit any concerns.[307]

279. I note this change has been implemented at JHC, but the PARROT tool itself is not a JHC document but a Child and Adolescent Health Service WA document. In that context, the Dhar family submit that consideration should be given to amending the PARROT chart with respect to family/clinician concern such that it is not a binary observation, but rather has degrees of concern. I note the chart itself has a lot of information already contained in it and has some difficulty being confined to a single page, although it works best in that format. Therefore, I am reluctant to make a specific recommendation in this regard. However, I am aware that the Department of Health, which encompasses CAHS, wishes to be informed of areas for improvement that might arise out of this inquest, with a desire to be proactive. With that in mind, I make the following recommendation.

280. As noted above, following Sandipan's death, JHC also conducted a SAC 1 investigation and a report was prepared, which I have referred to in this finding as the Root Cause Analysis. The SAC 1 review panel acknowledged that with the benefit of hindsight, there was a missed opportunity to perform blood tests during Sandipan's first presentation to JHC, which may have identified his ALL earlier. The SAC 1 review panel also considered there was a possible misinterpretation by staff of parental concerns that may have influenced the decision not to take bloods. However, the SAC 1 review panel concluded overall that the care provided to Sandipan in his first and second presentation was appropriate and there were no clinical indicators of ALL to justify blood tests at that time. The SAC 1 review panel also did not find any system failures that directly contributed to the outcome in Sandipan's case, although the review panel identified some areas for improvement and made nine

[305] Exhibit 2.
[306] Exhibit 2.
[307] Exhibit 2 and Attachment 4.

corresponding recommendations. Dr Hartley advised that since March 2024, JHC has implemented all of these recommendations.[308]

281. Of particular relevance to this case, Dr Hartley advised JHC gave consideration to how to provide discharge summaries to patients and families when they leave the ED, which led to the development of a protocol.[309] IT encourages staff to call a patient or their guardian if a patient leaves the ED before the treating or senior doctor has communicated the discharge instructions, and allows for an electronic discharge summary to be emailed when a patient leaves the ED without their discharge summary.. Further, a text message alert system has been incorporated into the discharge protocol to allow for messages to be forwarded to parents in the event that communication is required after discharge from the ED. Linking in to the JHC External Review, Dr Hartley also advised the JHC ED discharge summary has been reviewed to include a section to capture patient, parent or caregiver questions or concerns in relation to the treatment plan, and a section where the medical team can then document their responses to those concerns.[310]

282. As for the JHC External Review, Dr Hartley advised that due to the media interest and parental complaints associated with Sandipan's death and the other child's 'near miss', the two cases were brought to the attention of Ramsay Health Care's national executive and the State Manager of Ramsay suggested to the national executive that an external review of JHC's paediatric services be conducted. Efforts were made to identify a hospital with a similar profile to JHC and Gold Coast University Hospital was nominated for that reason. It was noted in these discussions amongst the national executive that Ramsay's CEO knew one of the doctors who eventually became involved in the review, Dr Bell, and this was then considered by the State Manager of Ramsay and it was ultimately determined that Dr Bell, along with Dr Braganza and the other members of the review panel would be involved. From the perspective of JHC staff involved in coordinating the review, any potential conflict of interest was considered and they were ultimately satisfied Dr Bell's relationship with the Ramsay CEO would not impact upon her ability to participate in the review. Dr Hartley advised that he had absolute faith in the panel members' expertise, integrity and professionalism. In hindsight, it would have been preferable for Mr and Mrs Dhar to also be informed of the relationship, so that they could raise any concerns if they wished and to avoid any hurt from a perception that relevant information had been kept from them. However, there is no suggestion now that the independence of the review was, in fact, compromised by any personal relationship.

283. Recommendation 8 related to education and information around parental concern. Dr Hartley advised in May 2025 that JHC had recently received the education resource for the latest version of the PARROT tool from Perth Children's Hospital working party, which incorporates further guidance on assessing family concerns. Importantly, the education resource emphasises that family know their child the best and can recognise early signs of deterioration, so they should be actively consulted in considering signs of deterioration, such as new confusion.[311] To strengthen

[308] Exhibit 2.
[309] Exhibit 2, Attachment 3.
[310] Exhibit 2.
[311] Exhibit 2, Attachment 4.

assessment of family concern, JHC has also included a tool to assess parental concern in the ED consumer brochure (adapted from the tool recommended by the JHC External Review panel). Further, linking to the JHC External Review recommendation around this issue, JHC rolled out a new Sepsis Pathway in February 2025, which is a statewide pathway.

284. As part of the review of this case, Dr Hartley advised JHC had also given consideration to developing a policy relating to blood testing in children. However, it was acknowledged the JHC External Review Panel identified some concerns about possible over-testing, as well as the need to weigh up the distress such testing can cause to infants and the time commitment for an inpatient test, noting the process of taking a sample can take some time and the results for a blood test in the ED are on average 2.5 hours. It was determined that the decision regarding performing blood tests is a clinical decision dependent on the facts in each case and there is no 'one size fits all' protocol that could safely be applied to every patient, so no protocol has been developed.[312]

285. One particular area of improvement that Dr Hartley emphasised in his evidence is centred around increased consumer representation in the systems and processes in the hospital. Dr Hartley advised JHC has significantly increased the consumer representation that the hospital has in key decision-making, in particular within the ED. Mr Dhar has personally assisted in that regard, taking the time to meet with JHC staff to provide his feedback on the proposals, which Dr Hartley acknowledged has been an incredibly valuable part of the change process. The focus has been on improved communication between ED doctors and patients and their families, in the form of checklists as part of discharge that have improved safety netting and the provision of electronic discharge summaries to ensure good information sharing. Dr Hartley indicated his belief that there is still more work to be done in this space, but he felt positive about the changes already implemented.[313]

286. Dr Hartley also spoke in evidence about ways to improve service to CALD patients and their families, noting the demographics of the patients who attend JHC are diverse. Much of the relevant training in this area has focussed upon Aboriginal and Torres Strait Islander patients, given their health outcomes, but there are also many patients from the United Kingdom in the catchment area, and members of the Indian community form the third or further largest patient cohort after them. Dr Hartley indicated that JHC has introduced an online training module but is also keen to do more to ensure that CALD patients and their families do not suffer poorer outcomes due to communication issues, both through language barriers and/or cultural differences. Dr Hartley expressed the hope that JHC can be a leader in this area. However, he considers it is a whole of WA Health issue, noting that many of the junior doctors, such as Dr O'Hearrain, come from other hospitals for brief periods.[314]

287. Similarly, changes to the PARROT chart and the education around it are the responsibility of the Department of Health, rather than JHC. Dr Hartley commented

[312] Exhibit 2.
[313] T 428 – 429.
[314] T 429 – 430, 438.

that the recent education includes a particular new focus on assisting clinicians with questions to better elicit areas of parental concern.[315]

288. Another important change in paediatric care at JHC that has been implemented more recently is around using the paediatric department to strengthen the level of paediatric service in the ED by including an extra paediatric consultant in the roster in the ED to assist with the flow of children up into the new Short Stay Unit in the paediatric inpatient ward that has been established, along with a further rapid review clinic that will be run by specialist paediatricians co-located next to the short stay unit. Having heard much of the evidence at the inquest, Dr Hartley gave evidence he is increasingly convinced that the Short Stay Unit and clinic will make a very meaningful difference to clinical service delivery in the paediatric space.[316]

289. An audit was conducted which has led to guidelines for better clinical documentation, including how to document parental concern. Further, in order to strengthen assessment of family concern, JHC has separately included a tool to assess parental concern in the ED consumer brochure.[317]

290. Most importantly, noting the issues with discharge/safety netting in this case, JHC's ED discharge summary has been revised to include a section to capture patient, parent, or caregiver questions or concerns in relation to their treatment plan, and a section is being included where the medical team can document their responses to the concerns. This will then be signed by the patient or their representative, to confirm they have had the opportunity to ask clarifying questions and understand the safety netting advice.[318]

291. I am not certain what other form of training is contemplated by the Dhar family in addition to these changes. I urge JHC to consult with affected families, as suggested in the submission, to see if there is more that can be done from a parental perspective to ensure that parents and caregivers are empowered to understand what is occurring and be able to engage fully in the decision-making process. I do not suggest this should be the Dhar family, as that may be more than could possibly be asked of them in the circumstances. However, I am sure there are other families who can contribute in this regard.

CALD patients

292. With that in mind, arising from this case is the important issue of how clinicians can ensure good communication with patients and caregivers from culturally and linguistically diverse backgrounds (CALD patients)

293. JHC services the primary catchment areas of The City of Joondalup and The City of Wanneroo. Joondalup is one of the largest local government areas in WA by population and Wanneroo is among the fastest growing in Australia. Significant further growth is forecast in the northern coastal corridor over the next 15 years. The

[315] T 430.
[316] T 431; Exhibit 2.
[317] Exhibit 2.
[318] Exhibit 2.

cities of Joondalup and Wanneroo "are described as supporting a significant migrant population, compared to the metropolitan average."[319]

294. As noted earlier, Nurse Rocchiccioli agreed that there may be cultural differences in how parents express concern to health practitioners and although he tries to be more inquisitive when questioning culturally and linguistically diverse people, he agreed in evidence that there are "obvious opportunities in hindsight to understand parents' concerns more deeply."[320] He noted that in an emergency department all parents are actively very concerned about their children, so it can be difficult to gauge the level of concern. In hindsight, Nurse Rocchiccioli suggested that with the power of hindsight, he might have made greater efforts to understand their concerns, but he also acknowledged that there are always competing demands on his time, and in this case, it is known there were other higher priority children who came in, which drew his attention away.[321]

295. Dr O'Hearrain recalled clearly how Mr and Mrs Dhar were "very pleasant and reasonable"[322] on the night. He was asked at the inquest about what training, if any, he had received in relation to culturally and linguistically diverse patients. Dr O'Hearrain recalled he had done an 'e-module' about healthcare for Aboriginal patients, which emphasised the need to avoid using jargon when explaining things and the benefits of having an Aboriginal liaison officer who can facilitate a good exchange of information and ensure patients and their carers feel comfortable when talking to a doctor. The training did not extend beyond Indigenous Australians to other cultures.[323] Dr O'Hearrain did not think this training influenced how he interacted with Mr and Mrs Dhar, although he did explain that when talking to any patient he would generally avoid using complex technical terms and try to keep his explanations simple and speak in an informal manner. He would generally use his own judgment as to whether he felt an interpreter might be required. In the case of Mr and Mrs Dhar, he believed they had a very good grasp of the English language and he believed they could understand clearly what he was saying. However, he had no particular training to consider whether there might be cultural factors that could influence his own ability to assess their level of parental concern and he took at face value their compliance with the doctors' decisions. At the inquest, Dr O'Hearrain accepted it was possible there may have been a cultural aspect to their calm, polite demeanour and apparent reasonableness that was not at the forefront of his mind when he was talking to them on the relevant day.[324]

296. At the time he was caring for Sandipan, Dr O'Hearrain did not get the impression Sandipan's parents were placing significant importance upon a blood test being done. Having come to understand since that time that they felt they were asking for a blood test repeatedly and their request was being denied, Dr O'Hearrain gave evidence that in hindsight he wonders if he might have asked the parents a few more times, "to dig out any more concerns they might have had. Just was there anything that everyone

[319] Exhibit 1, Tab 14, p. 21.
[320] T 123.
[321] T 123 – 125.
[322] T 131.
[323] T 217 – 218.
[324] T 219.

was missing."[325] He agreed that after reflecting on this case, he and other doctors could benefit from more training on cultural factors that might affect good communication between patients and/or their carers, from culturally and linguistically diverse backgrounds.[326]

297. Dr Siow was also asked at the inquest about her level of awareness of cultural and linguistic diversity challenges at the time she saw Sandipan and spoke to his parents. Dr Siow gave evidence she was aware that different cultures may ask questions differently so she gauged some of her information from the non-verbal cues, including her impression of whether the parents were comfortable answering the questions she asked and if they were happy with the diagnostic process. Dr Siow gave evidence her usual practice is to share her thought process while making the clinical decisions and during that time the parents can comment and she will try to gauge what they think about her diagnostic reasoning and if it is in line with their thinking? For example, if they suddenly go quiet she will know that they are not happy with the reasoning, or if they appear highly anxious in response or voice their concern, she will respond to that information. In the case of Mr and Mrs Dhar, Dr Siow recalled they appeared calm and relaxed and she did not think at the time that they showed a heightened level of concern in response to her questioning and reasoning. She did not get the impression there was a language barrier and she did not sense through their body language any unhappiness while she took a history and formulated a diagnosis and management plan.[327]

298. Dr Siow stated that in her experience, parents who are highly concerned "typically voice specific worries, such as asking for blood tests, or may appear unusually quiet or disengaged."[328] In this case, Mr and Mrs Dhar maintain that is what they did, in the sense of specifically asking for blood tests. However, Dr Siow gave evidence she did not recall that request being made and she said she was unaware they were, or might have been, expecting blood tests. Dr Siow recalled she did not observe any signs of heightened worry in their behaviour.[329]

299. It was put to Dr Siow that the conduct of Mr and Mrs Dhar in taking their son to see a GP three times in seven days (with Dr Siow at least definitely aware of two of those visits) and then bringing their son directly to the ED demonstrated a high level of parental concern, separate to whatever impression may have been formed based on their demeanour in the ED. Dr Siow agreed they were concerned, but she did not get the impression they were highly concerned at the time, although she agreed in hindsight she may have been mistaken. [330]

300. Dr Siow had completed some training in cultural and linguistic diversity as part of her training as a specialist physician but also referenced her own culturally and linguistically diverse background as relevant to her understanding of the need to be open to the differences this can make to how information is provided and interpreted.

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[325] T 229.
[326] T 229 – 231.
[327] T 245 – 247.
[328] Exhibit 1, Tab 20 [89].
[329] Exhibit 1, Tab 20.
[330] T 343 – 348; Exhibit 1, Tab 20.

Dr Siow indicated that, with the benefit of what she has learned in this case, she would now specifically ask parents more targeted questions about their level of concern, and if it is a critical issue she will rephrase and ask the question several times to confirm that there is a good understanding. In this way, she obtains direct information about the level of concern, rather than simply forming an impression based upon non-direct questioning and body language.[331]

301. In this case, Dr Siow's evidence was that if she had understood that Mr and Mrs Dhar were very concerned and specifically hoping that a blood test would be performed, she believes she would have approached the issue of the blood test differently. Although it would not have immediately prompted her to order a blood test, Dr Siow indicated she takes parental concern seriously and she believes she would have discussed the pros and cons of doing the test and then reached a decision in consultation with the parents.[332]

302. The Root Cause Analysis or SAC 1 investigation team acknowledged that consumer representation was not included in the root cause analysis panel, due to time-scheduling constraints. It was recommended that JHC establish a process to include consumer representation as part of its SAC 1 process. In my view, it would be important for that consumer representation to also, where possible, reflect the cultural factors that might have influenced an outcome in a particular case. I note there was an appropriate representative included in the JHC External Review, as well as a community member with lived experience.[333]

303. Dr Braganza suggested that the most effective way for emergency departments and other health services to bridge the gap of cultural and linguistic differences is to ensure that the cohort of clinicians are representative of the community. Dr Bell suggested this could also be strengthened by having community representatives as part of these organisations.[334]

304. Important in the exchange of information for families and caregivers to understand they can challenge the clinicians and clinicians need to be open and invite this kind of discourse. Dr Bell referred to the need to empower family members to express themselves and that should include an understanding of the different ways people from various backgrounds may choose to communicate and ways to ensure people feel comfortable to communicate, in order to ensure there is shared decision-making. Dr Bell commented that the difficulty is that there needs to be systems created where "time at the bedside is valued"[335] so that a relationship of trust can be built, but that can be challenging in a busy emergency department, although not insurmountable.[336]

305. Professor Lawton noted that there is no one single accepted definition for cultural and linguistic diversity, as it incorporates various demographic data such as country of birth, language spoken at home, English proficiency, religion, parents' country of

[331] T 344 – 345.
[332] T 346.
[333] Exhibit 1, Tab 13.
[334] T 282 – 283.
[335] T 284.
[336] T 282 – 284.

birth and year of arrival in Australia. Cultural and linguistic diversity is specifically recognised in the WA sepsis pathway as a risk factor for sepsis and Professor Lawton observed that as well as language barriers, there may be socio-cultural barriers that might prevent members of the CALD population from challenging healthcare providers. That would appear to have been a factor in the case of Mr and Mrs Dhar. Therefore, as a general principle, careful inquiry and cultural sensitivity are required in dealing with the CALD population in the ED.[337]

306. Mr Dhar and his wife are both multi-lingual, being able to speak and understand Bengali, Hindi and English, although Mrs Dhar is less confident in speaking English than Mr Dhar. They live in Butler, in the catchment area for JHC, and Mr Dhar has worked and studied in Australia for many years. It could appear to someone meeting the couple of the first time that they have no language barriers to communicating in English, including when speaking to health practitioners. However, speaking and understanding a common language is only one part of good communication, and in this case Mr Dhar explained there were cultural barriers that affected good communication between his family and the doctors and nurses they spoke to in relation to Sandipan's care. [338]

307. Mr Suresh Rajan has a reputation as a long-standing advocate in Western Australia for issues relating to equity, inclusion and multicultural affairs. He was worked for many years in both government and non-government sectors to promote the rights and wellbeing of CALD communities, with a particular focus on health, disability, and human rights. Mr Rajan has served on multiple boards and advisory committees at both the State and Federal level in relation to the equitable treatment of people from migrant and refugee backgrounds in Australia, and has also supported individual families in individual cases to navigate often complex bureaucratic systems where cultural misunderstanding can occur. Mr Rajan has also previously supported individual families through the coronial inquiry process and personally assisted in highlighting the cultural and linguistic barriers and systemic failings that can contribute to poor health outcomes for culturally diverse patients in our hospitals.[339]

308. Mr Rajan has provided support to Mr and Mrs Dhar throughout this difficult case and has formed the belief, which aligns with the family's belief, that there were serious systemic issues in this case that may have impacted the timeliness and quality of the care Sandipan received, as well as having compounded their grief in the aftermath of his sudden death. Mr Rajan noted that some of these issues have been identified by this Court and other inquiries which have some distressing similarities to this case.

309. Based upon his personal experience and the experiences of others, Mr Rajan drew the Court's attention to the particular challenges faced by culturally and linguistically diverse families in Western Australia's health system. Mr Rajan noted these challenges are not unique to the Dhar family, but instead are "sadly, pervasive and persistent."[340]

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[337] Exhibit 1, Tab 24 [95], [99] – [100].
[338] Exhibit 1, Tabs 10.1 and 10.2.
[339] Exhibit 1, Tab 25.
[340] Exhibit 1, Tab 25 [5].

310. Mr Rajan observed language barriers are often the most immediate and visible problem, and while interpreters are theoretically available in health settings to overcome this obstacle, in practice he believes families are frequently left without adequate interpretation services. This can result in critical gaps in understanding medical advice, issues with consent processes and ability to carry out care instructions. Mr Rajan observed that in "moments of crisis, these gaps can mean the difference between life and death."[341] While in this case Mr Dhar, in particular, has an excellent grasp of the English language, his wife is less proficient, and in any event even people who speak English as a first language can often find complex medical terminology difficult to understand. However, more importantly in this case, is the less visible issue of cultural barriers to good communication.

311. Mr Rajan advised that cultural understandings of authority – particularly in Indian culture – can play a significant role, and that appears to have been the issue in this case. As explained by Mr Dhar from his personal perspective, Mr Rajan noted that in Indian communities, "doctors are held in high esteem and are often seen as figures of unquestionable authority. It is not culturally normative to challenge a doctor's decision or to question medical processes. This deference to authority can be misinterpreted by hospital staff as indifference or disengagement, when in fact it is a sign of respect and deep cultural conditioning."[342]

312. Further, Mr Rajan advised that families from these backgrounds may often be reluctant to 'rock the boat' or appear confrontational, which in a busy, high pressure environment like a hospital ED, can result in their concerns being "under-voiced, overlooked, or dismissed."[343] It was apparent from some of the descriptions given by the JHC ED clinicians who dealt with Mr and Mrs Dhar that this reluctance to appear confrontational may well have been misinterpreted as a lack of parental concern. Mr Rajan observed that when critical concerns are not expressed because families fear being seen as difficult or disrespectful, "the system fails to receive the feedback it needs to correct course."[344] It appears to me that this description is apt in this case. I accept the evidence of Mr Dhar that he and his wife were extremely concerned for their son but felt constrained in their ability to express that concern for fear of appearing to be disrespectful of the doctors involved in their son's care. I accept they raised at least with Dr O'Hearrain their wish for a blood test to be performed, and they also relied upon the GP referral letter suggesting a blood test would be appropriate, no doubt hoping that the doctors would take more heed of the opinion of a colleague. When Dr Siow informed them she did not intend to order pathology testing at that stage, they would have interpreted that decision in the context of knowing what was contained in Dr Rana's letter and what they had communicated to Dr O'Hearrain. To continue to insist upon it, in that context, would be very difficult for them culturally, although it seems from some of the comments made in the JHC External Review that this is what the system would generally expect of concerned parents

[341] Exhibit 1, Tab 25 [6].
[342] Exhibit 1, Tab 25 [7].
[343] Exhibit 1, Tab 25 [8].
[344] Exhibit 1, Tab 25 [8].

313. In Mr Rajan's opinion, based upon his good understanding of Mr and Mrs Dhar's recollection of events along with the information he has been able to access in supporting the family, there were cultural factors that led to the significant concerns of Sandipan's parents to be misunderstood and underappreciated by the doctors and nurses involved in Sandipan's care at JHC. From his experience, Mr Rajan inferred that Mr and Mrs Dhar's requests for a blood test "would not have been communicated in the same forthright manner as someone from an Anglo background. Similarly, disagreement with a doctor's recommendations would have been communicated indirectly so as to avoid confrontation and disrespect." When clinicians are busy and distracted by multiple demands on their time, these subtle differences could easily be overlooked.[345]

314. Mr Rajan submitted that unless these cultural dynamics are understood and proactively addressed by healthcare professionals, "they can and do lead to poorer health outcomes for people from multicultural backgrounds."[346] Therefore, it is important that lessons are learned from this case to ensure that hospitals in Western Australia become culturally safe environments for all patients and their families. This requires more training and institutional awareness of these issues to ensure that health services, and their staff, are culturally competent and culturally safe.

315. Mr Rajan explained in evidence that the Dhar family are from the South Asian community more broadly and the Indian community in particular. Mr Rajan advised that at the time of the inquest he had been assisting 14 families on their journeys navigating the WA healthcare system, and 13 of those families were from the Indian community and 12 related to deaths of family members. Mr Rajan observed that, from his perspective, the common element in these cases is "the gentleness, the lack of questioning of a professional judgment that is provided to you, and the status of doctors and medical professionals generally"[347] in the Indian community. Mr Rajan advised that there are over 2,700 people of Indian descent in Joondalup, but those statistics do not capture all of the people affected by some of these cultural differences, as the statistics measure place of birth but do not always capture ethnicity. He observed that to get a more accurate picture of the demographic requires overlaying place of birth with languages spoken, which will reveal a large proportion of people who identify as being of Indian ethnicity. Noting Mr Rajan's experience that people of Indian ethnicity are overrepresented in many of these adverse health events, he advocates for a health system that recognises cultural differences in how people communicate with doctors and advocate for their loved ones. As Mr Rajan aptly expressed it, "you cannot predicate a health system on how hard you thump the desk."[348]

316. Mr Rajan suggested that the WA health system should consider getting an epidemiologist to do an assessment of what cohorts are present, which will provide better data from which hospitals can predicate cultural policies. For example, as Dr Hartley indicated, there is a significant focus on Aboriginal and Torres Strait Islanders patients in cultural learning for staff, which is right and appropriate in

[345] Exhibit 1, Tab 25 [10].
[346] Exhibit 1, Tab 25 [9].
[347] T 471.
[348] T 472.

Western Australia given the often poor health outcomes for these patients. However, in a hospital such as JHC, there is also a need to recognise that there will be other significant cohorts of patients from the United Kingdom and of Indian ethnicity, who are likely to present different communication challenges. Dr O'Hearrain, who is Irish, gave the example in his evidence that Irish people "can say they're grand, and that can mean a whole spectrum of things,"[349] ranging from they're good to they're having the worst day of their life.

317. As well as cultural norms around respect for doctors, Mr Dhar referred in his evidence to his concern that if he raised his voice and behaved aggressively in the ED, he might have got himself into trouble with security or the police and this might have led them to be removed from the ED. However, he now faces the suggestion that he was too polite and too gentle in advocating for his son, which he feels has disadvantaged them as parents. Mr Dhar urged me to consider how change could be brought about to ensure that parents can strongly advocate for their children without the fear that they may be accused of aggression. [350]

318. The Dhar family submitted that a recommendation that may improve engagement and communication with CALD patients could involve ensuring a social worker with CALD communities training is available either in person, or by telephone, to assist communication between clinicians and CALD patients and their caregivers in the paediatric pods. I note JHC has already reviewed the social worker service in the ED, as part of their response to the JHC External Review recommendations. In my view, it is appropriate for JHC to also consider this important aspect of the work that social workers can do to facilitate good communication where there may be challenges that are not easily understood by busy clinicians. I note Dr Hartley's evidence that JHC is keen to be active in the vanguard of improvements for CALD patients and their families, and this is an area where that could be demonstrated.

RECOMMENDATIONS

319. I have set out in considerable detail above the findings of the various reviews that have been conducted into the events surrounding Sandipan's sudden death, and changes that have subsequently been made, to give some context to any recommendations that I now make. The Dhar family have provided detailed submissions on further recommendations they suggest may also benefit the community.

320. It is difficult to make recommendations that tailor neatly into what changes are already in effect, so I acknowledge that some of the recommendations I make now will to some degree simply confirm, or build upon, changes already in place or being progressed independently of the coronial process.

[349] T 230.
[350] T 464.

Recommendation 1

I recommend that JHC review and update its ED discharge and follow-up documentation and guidance so that time-based advice is conveyed with sufficient clarity to avoid misinterpretation. Where a specific date is not clinically indicated, staff should prefer time-window descriptors (e.g., "within 24–48 hours" or "early next week") and ensure that the verbal advice and the discharge summary use consistent wording. JHC should audit a sample of paediatric ED discharges within six months to confirm consistent use.

Recommendation 2

I recommend that JHC reinforce, through routine clinician education and documentation guidance, the importance of clearly distinguishing "infection" from "sepsis" in family communications and discharge information, including a short plain-language explainer on how tests (e.g., urinalysis, bloods) inform next steps and information as to signs to look for that might prompt early return, as part of safety netting, particularly in paediatric cases.

Recommendation 3

I recommend that JHC maintain and resource the Paediatric Rapid Access Review Clinic, and that its effectiveness be evaluated (e.g., time to review after ED discharge; unplanned ED re-presentation within 72 hours and 7 days; unplanned admission) to guide future planning and resourcing.

Recommendation 4

I recommend that JHC maintain its post-departure text-message/call-back protocol for patients who leave before planned investigations or treatment are completed, and periodically evaluate its operation (e.g., contact rate, time-to-contact, outcomes of contact) at six and twelve months, using results to refine triggers and resourcing.

Recommendation 5

I recommend that JHC review and confirm that paediatric-specific triggers exist and are consistently applied to initiate same-day contact where a child did not wait (DNW) or left after treatment commenced (LATC) and either (a) left before completion of an investigation central to the plan (e.g., urinalysis in a prolonged-fever assessment), or (b) other risk indicators persist. A short compliance audit at six months is suggested.

Recommendation 6

I recommend that JHC consider what additional education can be provided to all clinical staff at JHC, with a particular focus on ED staff providing paediatric care, to ensure they are aware of potential cultural differences in the ways that parents and caregivers communicate parental concern. Further, with the benefit of that training, there should be a CALD-aware trigger within the ED safety netting to ensure that where language/cultural differences are identified, staff offer interpreter and/or social work support and record the offer and any assistance provided in the clinical record. Any such cases should be included in the six month audit of paediatric ED discharges to monitor whether it is assisting CALD families to better engage with clinical staff in the ED, or whether more supports are required for CALD families.

Other suggested areas for recommendation

321. I note in the context of some of the other recommendations suggested, that Mr and Mrs Dhar have already lodged a petition with the Legislative Council in relation to their wish for the Department of Health to review the private/public partnership with Ramsay Health Care.

322. Some other suggestions are much broader than the scope of my powers, such as the method in which health professionals are managed, which is done at a national level.

323. One other proposed recommendation I would like to specifically address is the Dhar family's request that I consider how to change the mentality of the health care providers in this state to ensure that health professionals listen to patients and their families. I can only respond that it is Mr and Mrs Dhar's willingness to speak out and share their story, despite their pain, that is likely to bring about the greatest change. This inquest has generated public interest, and Mr and Mrs Dhar's willingness to also engage with JHC directly and to advocate through members of parliament are all part of the change movement. No greater learning can occur than for health professionals to hear what tragedy can befall a family if communication breaks down between parents and doctors when a child is unwell. Sadly, Sandipan's death is not the first time the people of Western Australia have witnessed such an event, but it is without doubt Mr and Mrs Dhar's willingness to speak out about Sandipan that has generated discussion about how systems, as well as individual practices, can be changed for the better of all families.

324. The WA Department of Health has requested it be included in any dissemination of recommendations, so that they can monitor them and consider whether they should be more broadly implemented, which I consider to be a very positive action by the Department, and should provide reassurance to the Dhar family that the lessons learned from Sandipan's death will be considered broadly within the WA health system.

CONCLUSION

325. As noted in the materials before me, Sandipan was by all accounts a remarkable little boy. He could stand by the age of five months and walk at seven months' of age. At 21 months' of age, he spoke both English and Bengali in sentences and loved to attract the attention of passers-by and engage in conversation with them. He had always been healthy and well until the last few weeks before his death. In those last few weeks Sandipan had multiple visits to his GP and two presentations to JHC ED, which underscores the dramatic change in his health that his parents witnessed. They became increasingly concerned as his fever persisted, despite diligent administration of medications and regular medical review, and did their best to raise the alarm and get help from their son.[351]

326. As it transpired, Sandipan had developed a rare, but not unknown form of childhood leukaemia. Diagnosis of this illness at an early stage can be difficult, as the symptoms are similar to many other, non-life-threatening, viral illnesses. However, there were features of Sandipan's presentation that could, and I accept should, have alerted the clinicians who were treating him to the possibility that his likely viral illness of tonsilitis may have become complicated by bacterial sepsis. I am satisfied that there was an opportunity for an experienced clinician, such as Dr Siow, to have identified that Sandipan had a more serious health issue than a simple viral illness, based upon the fact he was a 21 month old child with a history of intermittent fevers for three weeks and accepting there was significant parental concern present, based at a minimum upon the fact he had multiple health presentations in a few days leading to his parents bringing him to the ED with the GP referral letter. In those circumstances, I consider it was incumbent upon Dr Siow to inform herself personally of the contents of the GP letter, which would have alerted her to the recommendation that a blood test be performed. This might have prompted some further discussion with Sandipan's parents about the reasons why Dr Rana had suggested a blood test, that may have led to an opportunity for Mr and Mrs Dhar to explain their desire for Sandipan to have a blood test due to their high level of concern that something was seriously wrong with their little boy.

327. Mr Dhar bravely gave evidence at the inquest to speak to his recollection of events and the impact the loss of Sandipan has affected his entire family. Sandipan's death has devastated his parents and older brother and will continue to have a lasting impact on their family unit, even as a beloved daughter has joined them. It has also had a lasting impact on the clinicians involved in his care and the broader community. Knowing now that Sandipan had a likely treatable disease, if it had been diagnosed in time, has caused important questions to be asked about how we can ensure that similar cases in the future are not missed.

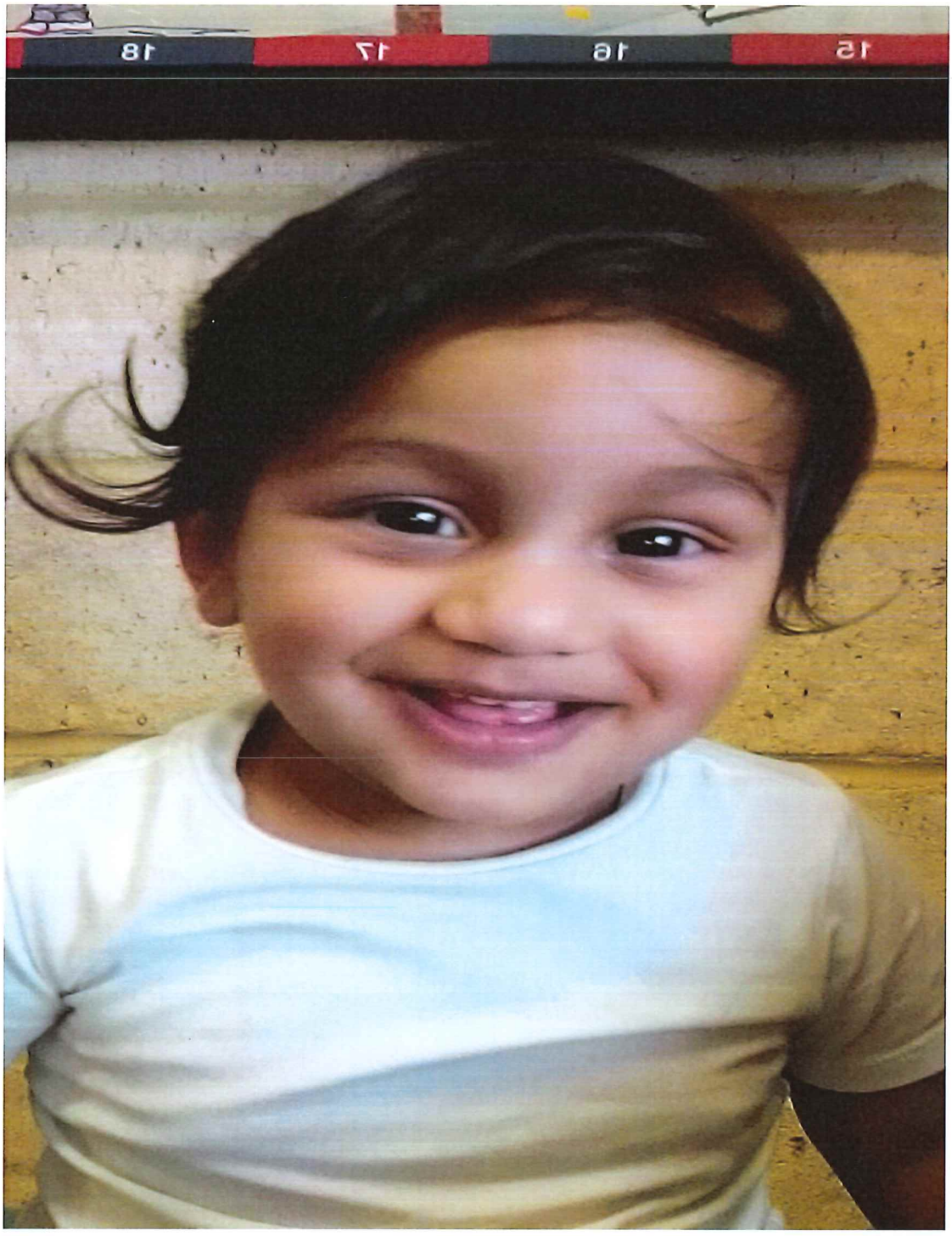
328. Mr and Mrs Dhar are passionate in their desire for meaningful change to come from Sandipan's death so that other lives will be saved. Mr Dhar's last words in evidence were to ask me to make sure that his son should not be a number only.[352] I can assure Mr Dhar now that Sandipan will never be just a number. His death has already led to significant change being implemented at JHC to make it safer for paediatric patients

[351] Exhibit 1, Tab 14.
[352] T 469.

and their families and I am confident that more change will come from this inquest process.

329. I extend my deepest condolences to Sanjoy, Saraswati, Mrinal and Oikantika. I know that reading this inquest finding will in many ways exacerbate their grief, but I hope they feel that the process has ultimately led to meaningful change and a safer future for other families.

S H Linton
Acting State Coroner
26 March 2026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