JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	24 AUGUST - 2 SEPTEMBER 2022
DELIVERED	**:**	22 FEBRUARY 2023
FILE NO/S	**:**	CORC 851 of 2021
DECEASED	**:**	CHAVITTUPARA, AISHWARYA ASWATH

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Tyler assisted the Coroner.
Mr T J Hammond (Blumers Lawyers) appeared for the Chavittupara family.
Ms C Thatcher SC with Mr D Harwood and Mr T Ledger (SSO) appeared for the Child and Adolescent Health Service and Dr Wood, Ms S Baker, Dr Cross, Dr Hale, Dr Dewsbury, CNS Kennedy, Ms Newton-Cremers, Ms Wells, Ms Lytwyniw and Mr Vijayaraghavan.
Ms B Burke (ANF) appeared for Nurses Taylor, Vining, Hanbury and Davies and Mr Olson and Professor Della.
Ms R Young (Minter Ellison) appeared for Dr Teo.
Mr T Palmer SC (Panetta McGrath) appeared for Dr Hollaway.
Mr G Donaldson SC (Dominion Legal) appeared for Dr Aresh Anwar.

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Aishwarya Aswath CHAVITTUPARA*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, Perth, on 24 August 2022 - 2 September 2022, find that the identity of the deceased person was* ***Aishwarya Aswath CHAVITTUPARA*** *and that death occurred on 3 April 2021 at Perth Children's Hospital, 15 Hospital Avenue, Nedlands, from multiorgan failure due to fulminant sepsis (streptococcus pyogenes) in the following circumstances:*

TABLE OF CONTENTS

INTRODUCTION ... 4
BACKGROUND ... 5
STRUCTURE OF PCH ED AT THAT TIME ... 8
ARRIVAL AT PCH: TRIAGE ... 10
REVIEW BY DR TEO ... 14
OBSERVATIONS TAKEN BY NURSE VINING ... 18
THE NEXT HOUR ... 28
BRIEF REVIEW BY DR HOLLAWAY ... 32
INITIAL CARE IN POD B ... 34
RESUSCITATION ATTEMPTS ... 36
POST MORTEM FINDINGS ... 40
DR SPEERS' OPINION ... 42
Timing of the Diagnosis and Treatment of Sepsis ... 47
DR NAIR'S OPINION ... 54
STAFFING AT PCH THAT DAY AND PRECEDING ... 62
ROOT CAUSE ANALYSIS (SAC 1) ... 67
NURSES' 10-POINT PLAN ... 69
INQUIRY ... 73
RESPONSE BY CAHS PRIOR TO AND AFTER 3 APRIL 2021 ... 76
PROGRESS ON RECOMMENDATIONS ... 84
Triage ... 86
Waiting Room Nurses ... 88
Aishwarya's CARE Call ... 90
Tools for Identification of Sepsis ... 92
Dedicated Supernumerary Resuscitation Team ... 95

Moving Children's Care Closer to Home 96
STAFF RESPONSE TO CHANGES 96
COULD AISHWARYA HAVE BEEN SAVED? 98
COMMENTS ABOUT THE PUBLIC HEALTH SYSTEM 101
RECOMMENDATIONS.. 102
Nurse-to-Patient Ratio.. 103
Recommendation 1 109
Supernumerary Resuscitation Team.. 109
Recommendation 2 109
Safe Harbour Legislation 110
Recommendation 3 110
Clinical Documentation Burden.. 110
Recommendation 4 113
Taking observations at Triage... 113
Recommendation 5 114
CAUSE AND MANNER OF DEATH 114
CONCLUSION.. 115

INTRODUCTION

1. Aishwarya Aswath Chavittupara was a happy and very loved little girl who died suddenly on 3 April 2021 at Perth Children's Hospital (PCH). She was generally healthy and had only been mildly unwell until the day of her death, so her death was entirely unexpected.

2. Later investigations revealed Aishwarya had died from multiorgan failure due to fulminant sepsis related to a bacterial infection (*Streptococcus pyogenes*, a type of Group A Streptococcus). Group A Streptococcal infections are common in children and can cause well-known conditions such as pharyngitis (sore throat), scarlet fever and impetigo (school sores). However, in rare instances, they can also cause a severe illness such as rapidly progressive sepsis, which occurred in Aishwarya's case. This type of sepsis can be difficult to diagnose, particularly in children, and without early treatment with antibiotics, it is sadly often fatal.

3. One of the hardest things for Aishwarya's parents to understand about their daughter's death is the fact that she had been left to wait for approximately an hour and a half in the waiting room of the PCH ED without treatment, before any of the doctors or nurses realised that she was critically ill. Aishwarya's parents realised that she was very sick and had desperately tried to raise their concerns with various members of the PCH staff, but no one appeared to take their concerns seriously until she was at the point of collapse. Urgent medical treatment then commenced, but it was too late to save her. Most of these events were captured on the hospitals CCTV footage, which is very hard to watch. Aishwarya's parents have never been able to bring themselves to watch it, having lived through each agonising minute on that fateful day.

4. Her devastated parents have been dedicated in their pursuit of answers as to why she died, why no one in the Emergency Department appreciated how critically ill Aishwarya was, and what steps can be taken to try to ensure that no other family suffers the pain of losing a child in this way? Amongst other things, Aishwarya's parents requested a coronial inquest be held into her sudden and unexpected death, in order to hopefully obtain some of the answers to those questions, and specifically to know whether she could have been saved with earlier treatment.

5. Aishwarya's death has undeniably had a profound impact on her family, friends, everyone involved in her care and members of the broader Western Australian community. No one who has heard about the death of this little girl would describe it as anything other than a tragedy. I note that Aishwarya died in the emergency department of the sole tertiary paediatric hospital in this State. PCH's emergency department specifically provides emergency and trauma services for children from the neonatal period through to late adolescence. It opened on 10 June 2018 and replaced the former emergency department at Princess Margaret Hospital.[1] Aishwarya's death in this traditionally safe place left many parents questioning whether it is safe to take their own child to PCH if they become critically unwell or injured.

6. I formed the view at an early stage that it was desirable to hold an inquest into Aishwarya's death, in particular to determine whether her death was preventable if she

[1] Exhibit 3, Tab 1, Report, p. 4.

had received earlier medical treatment at PCH. In addition, it was important from a public health and safety perspective to explore what happened and ensure that lessons are learnt from her death. The State Coroner then took the rare step of directing that the inquest hearing date be expedited, as it was important to ensure the answers to these questions were obtained as soon as possible, so that there continues to be public confidence in the State's only specialist children's hospital.

7. Prior to the inquest commencing, a number of other inquiries into the circumstances of Aishwarya's death were completed. The Child and Adolescent Health Service (CAHS), of which PCH forms a part, conducted what is known as a Severity Assessment Code 1 (SAC1) Clinical Incident Investigation (or Root Cause Analysis) and made recommendations for improvements. Unusually, that report has been made public by the State Government, so there are none of the usual issues of confidentiality surrounding the report. The report formed part of the coronial brief of evidence, and I address its recommendations later. I will refer to it as the Root Cause Analysis and Root Cause report, for ease of reference, although it was often referred to as the SAC 1 in the evidence.

8. Following the release of the Root Cause report, an Independent Inquiry into Perth Children's Hospital was initiated by the Director General of the Department of Health, Dr Russell-Weisz. That report was tabled in Parliament and also released to the public in November 2021. A large number of recommendations arose from that report. It again formed part of the brief of evidence in this inquest and I will refer to it as the Inquiry and Inquiry report when I refer to it later.

9. I mention these other inquiries and related reports to put this inquiry into a context. Many recommendations have been made and significant action taken to implement them, which is relevant for me to consider when determining whether there are any further recommendations I consider are appropriate to make arising out of this coronial inquiry. I note that the purpose of an inquest is not primarily to make recommendations, but rather to find answers, so that has been my chief focus for Aishwarya's family. They have not urged me to make any particular recommendation, but have asked me to give close consideration to that key question that I asked when I first directed that an inquest be held: was Aishwarya's death preventable if there had been earlier recognition of her sepsis and immediate treatment provided?[2]

BACKGROUND

10. Aishwarya's father, Muraleedharan Aswath Chavittupara (Aswath), and mother, Prasitha Prasanna Sasidharan (Prasitha), were both born and raised in India. Aswath moved to Australia in 2006. He married Prasitha in India in 2009 and Prasitha moved to Australia in 2011 to join him. By 2021 they had had four children together: Amrita, Aishwarya, Aaryan and Adithya. Aishwarya was born and raised in Perth with her parents and her three siblings. Aishwarya was the second oldest of the four children.

[2] Submissions on behalf of Aishwarya's family filed 18 October 2022.

11. Aishwarya's father established two successful businesses in Australia and her mother worked in the family business with him.[3] Until the events in April 2021, they were a happy, thriving and successful family. They all enjoyed good health and loved spending time being active together playing sport, especially soccer, and generally having fun as a family. Aishwarya was particularly close to her older sister, Amrita, and they were described as "always laughing together."[4]

12. Aishwarya was generally a fit and healthy little girl. She happily attended Morley Primary School at the time of her death. Aishwarya's parents described her as "always smiling."[5] She loved performing and being on camera and had recently won the school talent show, 'Morley's Got Talent,' performing a magic act with Amrita. They had enjoyed it so much that they were planning on starting a YouTube channel magic show.

13. On Thursday, 1 April 2021, Aishwarya went off to school as usual. It was the last day of school before the start of the Easter holidays, and the school ran a 'Rainbow Run' event for the students. This involved the children having fun running around throwing coloured paint at each other and shooting each other with spray coloured water. All of the children had fun and when Aishwarya and her siblings came home from school they were happy and excited. Aishwarya's father recalls nothing out of the ordinary.[6]

14. Aishwarya played soccer with her father, sister and brothers until dinner. After dinner, the children wanted ice cream. It was the start of the holidays, so they decided to go to Baskin Robbins as a special treat. They walked to the ice cream store, which was close to their home. Aishwarya had no difficulty walking with her brothers and sister, or eating her ice cream, and appeared fine. After returning home, they got ready to go to bed. It was a family tradition on Friday nights that they would all sleep together on mattresses on the floor. They called it 'carpet room night'. As it was the start of the holidays, they decided to do carpet room night early. The whole family went to sleep together at about 10.30 pm with the air-conditioning running. At that stage, Aishwarya's parents saw nothing to cause them any concern.[7]

15. Aishwarya woke up in the early hours of Friday, 2 April 2021, and told her mother she had a headache. Her mother thought at the time that Aishwarya might be feeling unwell because of the late night, the ice cream or from sleeping under the air conditioner. She went back to sleep, but when Aishwarya woke again at about 6.00 am she still complained of a headache. Her mother recalls that Aishwarya had a temperature, although her father recalls they took her temperature and it was in the normal range. In any event, it was clear she was unwell and Aishwarya's mother gave her a dose of Panadol before she went to work.[8]

16. Aishwarya's paternal grandmother was staying with them at the time. She was looking after the children at home that day. After Aishwarya's mother went to work, she

[3] Exhibit 1, Tab 11.2 and Tab 12.2.
[4] Exhibit 1, Tab 11.2, [22].
[5] Exhibit 1, Tab 11.
[6] Exhibit 1, Tab 11.2.
[7] Exhibit 1, Tab 11.2 and Tab 12.2.
[8] Exhibit 1, Tab 11.2 and Tab 12.2.

received a call from Aishwarya's grandmother to tell her that Aishwarya had vomited. Aishwarya's mother returned home to care for her. She gave Aishwarya more Panadol when six hours had passed between doses. Aishwarya vomited another three times after her mother returned home, but then she seemed to begin to settle at around midday.[9]

17. Aishwarya's parents assumed she had some sort of viral illness or other 'bug', as children commonly do, so they were not overly worried at this early stage. She was not eating much, but they continued to make sure she kept her fluids up by giving her regular drinks. She did not vomit again and generally spent the day resting. In the afternoon, Aishwarya was eating rice soup, which reassured her mother that she appeared to be getting better. Her father recalls that Aishwarya's temperature kept spiking, but it was never elevated to a point that was worrying and they dealt with it by providing her with more Panadol.[10]

18. Aishwarya went to bed with her mother that night so that she could look after her. Aishwarya woke up a few times and her mother gave her regular Panadol and warm water to drink.[11]

19. Aishwarya was still unwell when she woke up on the morning of Saturday, 3 April 2021. Her mother recalls Aishwarya said she had a sore body, particularly her legs and hands, and her father remembers she said that she felt weak. Her parents were concerned she had not had much to eat the previous day, other than some rice soup, so her father went to the supermarket and bought Aishwarya's favourite cereal, Coco Pops, and some hydrolyte to drink. She was able to eat the cereal and drink some hydrolyte on his return home.[12]

20. Over the course of the day, Aishwarya appeared very tired, but was eating and drinking and wasn't vomiting, so they were not too worried. She stayed inside, resting on the couch, for most of the day. As the day moved into the afternoon, and Aishwarya still had not improved, her mother began to worry more and spoke about taking Aishwarya to hospital. Aishwarya's father recalled that Aishwarya really didn't want to go to hospital and he believed she started to pretend that she was getting better to avoid it.[13]

21. At about 4.30 pm, Aishwarya's mother noticed that Aishwarya's hands were cold and her forehead felt very warm. This was not something they had experienced with any of their other children's illnesses and Aishwarya's parents became very worried. It was at this point they decided to take Aishwarya to the PCH Emergency Department, despite Aishwarya's reluctance. Before they set off for hospital, they put a nappy on Aishwarya as they were worried about her having diarrhoea on the way and potentially not being able to get her to a toilet.[14]

---

[9] Exhibit 1, Tab 11.2 and 12.2.
[10] Exhibit 1, Tab 11.2 and Tab 12.2.
[11] Exhibit 1, Tab 12.2.
[12] Exhibit 1, Tab 11.2 and Tab 12.2.
[13] Exhibit 1, Tab 11.2 and Tab 12.2.
[14] Exhibit 1, Tab 11.2 and Tab 12.2.

22. Aishwarya's parents left their other children with Aswath's mother and together drove Aishwarya to PCH at about 5.00 pm. During the drive, Aishwarya kept saying that her hands were cold and her father became increasingly worried about them. He kept encouraging Aishwarya to rub her hands together to try to warm them up and move her arms and pump her fist. When her arms became tired, he asked her to hold his own hands to try to keep her hands warm.[15]

23. Aishwarya's parents recalled the drive to PCH took about 15 to 20 minutes. They parked in the basement and took the lifts up to the hospital's emergency department. Aswath recalled as they were entering the building he saw a big sign out the front that indicated the average wait time was 4 to 6 hours and another sign next to it that said the hospital would not tolerate abusive behaviour.[16] It is apparent that reading this sign had an impact on Aishwarya's parents and what they did in the next couple of hours to try and get the staff's attention. They did not wish to be classed as abusive, or do anything that might jeopardise urgent care being given to their daughter, and this influenced their behaviour later when waiting inside the Emergency Department.

24. Evidence was given at the inquest that the afternoons were generally when the long wait times would occur, and when the PCH ED was approaching those kinds of wait times, the sign about the length of wait would go up.[17] The signs discouraging violence and aggression had been introduced due to increasing reports of ED staff experiencing aggression from parents in the waiting rooms at times when waiting times were prolonged, which had also led to a security guard being brought into the ED at times to support staff safety. Obviously any violence or aggression towards hospital staff is unacceptable, but it is unfortunate that the signage had a negative effect on Aishwarya's parents that afternoon. I am informed the signage has changed significantly since that time.[18]

STRUCTURE OF PCH ED AT THAT TIME

25. I note that Aishwarya's death at PCH occurred during the COVID-19 pandemic. At the time, the WA borders had not been lifted, so we were fortunate in this State not to have the virus running rampant and there were very few restrictions in place in early April 2021, although a snap lockdown was imposed in Perth and the Peel District later that month. However, there was evidence the management of PCH had made some changes in preparation for the inevitable introduction of the virus into WA, and all health staff were conscious of trying to minimise the risk of infection.

26. At the relevant time in April 2021, the Emergency Department at PCH was separated into the following geographic areas:[19]

- a general waiting area;
- a triage area;

[15] Exhibit 1, Tab 11.2 and Tab 12.2.
[16] Exhibit 1, Tab 11.2.
[17] T 122.
[18] Exhibit 3.2, p. 71.
[19] T 141; Exhibit 1, Tab 13 [19]; Exhibit 2, Tab 40 [7].

- a resuscitation area;
- a fast-track area for injuries and broken bones;
- ‘Pod A’;
- ‘Pod B’;
- A waiting room for Pods A and B and fast-track;
- ‘Pod C’; and
- a waiting room for Pod C.

27. The patient beds were set up in cubicles in the pods, and the pods were where most of the patient care was provided.[20]

28. There was evidence Pods A and B were the high acuity areas and Pod C was a lower acuity area, which could only receive patients that were triage category 4 or 5 and were assumed to require only minimal intervention while waiting and after assessment and treatment would be potentially discharged. If it turned out a Pod C patient required more than that, they could be moved to Pod A/B and restreamed.[21]

29. Usually when a patient came to the Emergency Department, they would enter the general waiting area and wait to be seen by a triage nurse. A nurse would then triage the patient in the triage area and categorise the patient’s condition according to the Australasian Triage Score scale, which is a scale from 1 to 5, with 1 being the most urgent of patients who required immediate treatment (such as those who require resuscitation) and 5 being the least urgent and whom, according to the standard, should be seen within two hours.[22] The patient would then be allocated to either Pods A, B, C or fast track and directed by the triage nurse to the appropriate waiting area. The triage nurse would also enter the patient’s information into the Emergency Department’s electronic information system (EDIS) and also make a paper record of the triage assessment, as part of the medical file.[23]

30. To reduce the risk of infection during the pandemic, the general rule was that a patient would be assigned to:[24]

- Pod A if they were high acuity and had no respiratory symptoms;
- Pod B if they were high acuity and had respiratory symptoms; and
- Pod C if they were deemed to be of a lower acuity/less urgent nature.

31. In addition, some changes had been made to the triage area as a COVID 19 precaution and for security reasons, by the introduction of a clear plastic/Perspex screen to separate the triage nurse from patients and their families.[25]

32. I understand that there was usually no specific staff member attending to patients in the waiting rooms for Pods A, B and C, but there was allocated a ‘floater’ nurse in each of the pod waiting rooms, who would sometimes be in the waiting room and

[20] Exhibit 1, Tab 13 [19].
[21] T 122 - 123.
[22] Exhibit 1, Tab 13 [49].
[23] Exhibit 1, Tab 13 [49].
[24] Exhibit 1, Tab 13 [50].
[25] T 134; Exhibit 1, Tab 14 [14].

sometimes leave the waiting room to assist the medical staff with various matters. When the floater nurse was in the waiting room and free, they would assess the patients in the waiting room and also perform basic vital observations of the patients. If a floater nurse noticed a patient in the waiting room deteriorating, they would bring this to the attention of a consultant or other medical staff member.[26]

33. If this did not occur, then the understanding of at least one trainee registrar who was working in the PCH ED at the time was that patients were to be seen in the order in which they were listed in EDIS unless a consultant said otherwise. A consultant would routinely review the EDIS queue in order to be able to give the instruction to take patients out of order, where necessary.[27]

34. There are CCTV cameras in the triage reception area and the ED waiting area, which captured Aishwarya and her parents quite clearly during the time they were waiting. The CCTV footage shows their various interactions with the PCH staff, but it is only a visual recording so there is no audio of the conversations that were had. The evidence about the conversations comes from the various witnesses, as well as some of their notes. It should be noted that much of the treatment activity was taking place behind closed doors, away from the waiting areas. Therefore, the waiting area where Aishwarya and her parents are seated appears deceptively calm, as the real action was apparently taking place elsewhere.

35. The CCTV footage makes difficult viewing given we know the terrible outcome. I understand Aishwarya's parents, who lived every heartbreaking moment, have been unable to bring themselves to watch it. What it does show is Aishwarya's slow decline, her parents increasing distress, and the very obvious fact that they had no one clear person to go to in order to ask for help or with whom to raise their concerns. I am informed that this has changed since this time, and I will refer to the relevant changes later in this finding, but at the time, Aishwarya's parents had no obvious path available to them to escalate their concerns, other than approaching various staff who were going about other tasks and beg for help.

ARRIVAL AT PCH: TRIAGE

36. As there were no other families waiting in the triage reception area when they arrived, Aswath and Prasitha walked straight up to the triage desk and spoke to the nurse who was seated behind the screen, Registered Nurse Jacqueline Taylor. Nurse Taylor was qualified to work as a triage nurse, which is a specialised role, and had been working at PCH since it opened.[28] Nurse Taylor was working as the only triage nurse for the PCH Emergency Department on that shift and did not have anyone else to assist her with her duties.

37. Evidence was given that the layout of the triage desk made it particularly difficult for one nurse, on their own, to perform all of their duties as the triage nurse at PCH. The nurse was usually seated in the 'bubble' of the triage office, with the screen and the

[26] Exhibit 1, Tab 13 [55] – [61].
[27] Exhibit 1, Tab 13 [66] – [70].
[28] T 101; Exhibit 1, Tab 14.

distance from the patient preventing the nurse from making a physical assessment of the patient from the triage office. If the triage nurse wanted to physically assess a patient, she had to leave the triage office and exit through two locked doors using a swipe card and go into the general waiting area. This would leave the locked doors open, so other people could go through them into the Emergency Department while the triage nurse was occupied assessing the patient, and also put the nurse potentially in danger as there are no security staff or other hospital staff in that area. Nurse Taylor noted it was in many ways, "a security role on top of your clinical role"[29] as a result.[30]

38. Even if the triage nurse did come outside the office for the purpose of making a physical assessment, it was not (and still is not) the practice at PCH for the triage nurse to do a vital signs assessment at this time, and they do not have the necessary equipment available to them in that area to do so. Nurse Taylor indicated that there was an expectation that the triage nurse would remain in place and not leave the desk other than when it was necessary to escort a category 2 patient through to the department, or on the rare occasion they conducted a physical assessment of a patient, and these tasks then needed to be done as quickly as possible so the desk was not left unattended for long.[31]

39. Aishwarya's parents recalled that they approached Nurse Taylor at her desk and she asked them what was wrong. They recalled that they said they were worried about Aishwarya and that she had cold hands. Nurse Taylor asked Aishwarya's parents some additional questions and recorded the information they provided. Aishwarya's father said they did not specifically mention Aishwarya's nappy to any of the staff as they "felt this was obvious," although it is unclear why they thought it would be so. Nurse Taylor was unaware of this fact and said it might have prompted her to ask more questions, but wouldn't have changed her triage score if she had known.[32] Aishwarya's parents recalled that Nurse Taylor did not physically assess or touch Aishwarya, but only spoke to her parents through the window, which is reflected in the CCTV footage.

40. Nurse Taylor had an independent memory of this night and seeing Aishwarya, despite the many patients she has seen in this role and saw on this particular day. Consistent with Aishwarya's parents' recollection, Nurse Taylor recalled she did not go outside the triage office to physically review Aishwarya, but only looked at her through the window. She recalled Aishwarya's father had carried her in and Aishwarya was seated in a chair during the triage process. Nurse Taylor could see Aishwarya and one of her parents, but the other parent was obstructed by the computer screen, so she had to look around it to see them. The width of the desk at that time also made it hard to get close to see and hear them through the opening in the window.[33]

41. Nurse Taylor recalled that she asked questions about Aishwarya's medical history and symptoms and recorded the answers given by her parents in the electronic triage form. Aishwarya's mother mentioned her concern about Aishwarya's cool hands, so she

[29] T 104.
[30] T 102; Exhibit 1, Tab 14 [14] – [18].
[31] Exhibit 1, Tab 14 [16] – [19].
[32] T 120.
[33] Exhibit 1, Tab 14 [37].

recorded that information, along with her history of gastrointestinal diarrhoea and vomiting since the day before and the fact that she felt weak. Aishwarya herself seemed alert and quiet and complained of a headache when Nurse Taylor spoke to her directly. As noted above, vital signs were never routinely done at triage at PCH, so Nurse Taylor did not take any vital signs at this time.[34] Nurse Taylor said that Aishwarya was not grunting in pain (as was noted later) at that time and her symptoms appeared largely gastrointestinal.[35]

42. After Aishwarya's parents answered Nurse Taylor's questions, and she conducted what limited clinical assessment she could do from where she was seated, Nurse Taylor had to allocate a triage score for Aishwarya. Nurse Taylor explained that the process of triage is "effectively a rapid assessment of the patient for the purposes of determining the priority with which they need to be medically reviewed," so when she was looking at Aishwarya and speaking to her parents, she was not attempting to make a diagnosis of what ailed her. Rather, she was trying to assess how long she could reasonably wait on a busy night in the Emergency Department. The triage score reflects that waiting time.

43. On this night, Nurse Taylor allocated Aishwarya a triage category of 4, the second lowest score, which indicated that she was assessed as currently stable and should have a medical assessment within one hour.[36] Nurse Taylor was aware that patients with similar gastrointestinal symptoms to Aishwarya will usually be seen by a nurse in the waiting room before the medical assessment, and often have vital signs taken, and receive a nurse initiated oral fluid trial and analgesia in the waiting room, so that the doctor can see how they are tolerating fluids and if their vital signs have improved. As is noted below, that was indeed the plan for Aishwarya, although it did not eventuate in this case.[37]

44. Nurse Taylor told Aishwarya's parents they could take Aishwarya to the waiting room of Pod C and wait to be seen. At the time, she knew there were fewer patients waiting for assessment in Pod C. Nurse Taylor told Aishwarya's parents to follow the blue squares and go and wait on the blue chairs, which were in the waiting area for Pod C.[38]

45. According to the clock on the CCTV footage and the triage form, the triage process took a total of just under three minutes, commencing at 5.33 pm and concluding just before 5.36 pm. It was indicated at the inquest that the usual timeframe for triage would be expected to be two to five minutes, so that was within the usual timeframe.[39] That was the end of Nurse Taylor's involvement with the care of Aishwarya and she moved on to triage other patients.

46. I note that at the time of her triage, Aishwarya did exhibit a number of symptoms that could have led to a diagnosis of sepsis, including her mother's specific concern about her cool hands, which Nurse Taylor wrote down as it was Aishwarya's mother's main

[34] T 112 - 113; Exhibit 1, Tab 14 [37] – [40], [43] and Tab 14.1.
[35] T 120.
[36] T 110; Exhibit 1, Tab 14 [42] and Tab 14.1.
[37] T 111, 120; Exhibit 1, Tab 14 [45].
[38] Exhibit 1, Tab 14 [54].
[39] T 107.

concern. This was along with the fact that Aishwarya was not feeling well with gastro symptoms. Nurse Taylor gave evidence that she wasn't too concerned about this symptom on its own as "cool hands" is something that parents will quite commonly mention, often in the context of a child running a fever although she did not know if Aishwarya had a fever at the time. Nurse Taylor said this feature did not raise her concern about Aishwarya's circulation or possible haemodynamic compromise as Aishwarya did not seem pale or to have dry lips and it was not suggested she was more generally cool or showing signs of central shutdown.[40]

47. Nurse Taylor gave evidence that she was aware of sepsis and did not have any suspicion at the time she saw Aishwarya that she might be experiencing symptoms of sepsis. Nurse Taylor noted it is very difficult to diagnose sepsis and many of the symptoms are reflective of other issues, such as hydration, but she would have particularly been looking for any signs of altered level of consciousness, or lethargy, which was not apparent at the time of triage. If there had been such signs, or Nurse Taylor had suspected sepsis for any other reason, she said she would have left the triage room and done some physical tests on Aishwarya and then taken her through into the ED for treatment. However, her suspicion of sepsis was not raised at the time.[41]

48. Nurse Taylor also said she did not consider Aishwarya's parents to be more anxious than any other parent, noting that a lot of parents are anxious when they bring their child to the ED. She felt there was no difficulty in having her questions understood and received appropriate answers and she did not believe there were any barriers to their communication.[42]

49. In summary, Nurse Taylor saw Aishwarya for about three minutes and from what she could see visually and ascertain from her parents and Aishwarya herself, Nurse Taylor formed the impression Aishwarya presented as an ordinary case of gastrointestinal illness, a common reason for children to present at PCH.[43]

50. The triage process was the first missed opportunity for anyone at PCH to realise that Aishwarya was seriously unwell and required urgent treatment. I say that without intending any specific criticism of Nurse Taylor although I note that the expert evidence of Dr Nair, which I refer to later in this finding, did suggest that the triage process could have been more comprehensive, which might have led to a higher triage score of 3 instead of 4. This might have made a difference to how quickly she was seen, except that I note due to her parents proactive seeking out of staff, Aishwarya was actually seen much sooner than her triage score would have warranted, and actually saw a doctor for the first time within the timeframe of half an hour that would be recommended for a patient with a triage score of 3. She was also seen by a nurse much sooner than would ordinarily be the case for a less urgent patient. Therefore, the change in the triage scores is probably not that significant in this particular case.

[40] T 115 – 116, 126, 138.
[41] T 121, 137 - 139.
[42] T 118, 121 - 122.
[43] T 142 – 144.

REVIEW BY DR TEO

51. When Aishwarya's parents walked into the Emergency Department waiting room, they saw there were three waiting areas - one blue, one green and one orange. The first area was very full and busy. They noticed the orange waiting area was empty and was situated right in front of a desk where staff were stationed, which they thought was a good thing as they were worried about Aishwarya and they thought the staff, who they believed might be nurses, would be able to see Aishwarya from there. Accordingly, they took a seat in the quieter orange area. They were, in fact, seated near to the Pod C and Fast Track administration desk, where two administration staff members were working.

52. Aswath had been carrying Aishwarya and he put her down on a couch and then both parents sat with her and began to wait. Aishwarya's parents had been to the ED a few times before with their sons for various reasons, and had waited patiently on those occasions to be seen, as the problems were not urgent. However, both Aishwarya's parents were acutely aware that this time with Aishwarya was different and something was very wrong. Therefore, although they did not want to complain or bother the staff unnecessarily, they became very stressed and anxious when it became apparent that Aishwarya would not be assessed quickly. They said their instincts were telling them that they should speak to someone about Aishwarya, as "the seriousness of her condition had not been appreciated by anyone."[44]

53. About five minutes after they sat down, Prasitha got up and approached the desk. She was unsure of the position of the person she spoke to, although we know now that she spoke to Ms Deena Wells, a Health Information Administration Service ED clerk (ED clerk). Ms Wells was allocated to the Fast Track team section that day. Ms Wells was excused from giving evidence at the inquest for personal reasons, but she did provide a written statement. In her statement, Ms Wells recalled that Aishwarya's mother said words to the effect of, "my daughter is having white patches in her eyes."[45] Although Ms Wells is not a nurse, based on her many years of experience working in children's hospitals, the information made Ms Wells think that Aishwarya might be about to have a febrile convulsion, which can occur in a child with a high temperature. Ms Wells stated that this prompted her to turn around and speak to Dr Tony Teo, who was a trainee registrar allocated to Pod C for that shift.[46]

54. Dr Teo had been working in this position at PCH since February 2021, so a couple of months prior to this day. It was his first rotation as a paediatric trainee.[47] Dr Teo started his shift on this particular day at 2.00 pm. He recalled that when he started he was told by one of the ED Consultants that he should go to Pod C and help out as it was busy. He had the impression that the ED was understaffed, as compared to normal, and that there were more patients than normal for that time of day.[48]

[44] Exhibit 1, Tab 11.2, [51].
[45] Exhibit 2, Tab 40 [15].
[46] Exhibit 2, Tab 40.
[47] T 191, 194.
[48] T 175 – 176, 193; Exhibit 1, Tab 13 [86] – [91].

55. Dr Teo followed the instruction and went and started seeing patients in Pod C, with the understanding it was the lower acuity unit. He recalled there were about eight to ten patients in Pod C when he arrived and one other resident medical officer working with him. Dr Teo generally took patients in the order in which they were listed in the EDIS queue (which ranks patients through triage score and waiting time). He stated he would generally review them in a cubicle after either getting the patient from the waiting room or instructing a resident to do that. Dr Teo said he rarely assessed patients in the ED waiting area unless he was working in the fast-track area, which has fewer cubicles available.[49]

56. Dr Teo was seeing patients and did not take part in the formal patient handover at 5.30 pm. Shortly after that time, he was near the administration desk in Pod C when Ms Wells spoke to him about Aishwarya. Based on the CCTV footage, Dr Teo accepted this conversation occurred at 5.41 pm.

57. Ms Wells believed she said words to the effect that Aishwarya's mother had told her that her child has white patches in her eyes, and she wondered if the child was having a febrile convulsion.[50] Dr Teo's evidence was that he did not recall their precise conversation, but he did not think there was any reference to a febrile convulsion. He recalled Ms Wells saying that Aishwarya's mother was concerned about Aishwarya's eyes, and he agreed she may have mentioned white patches.[51] Dr Teo said that if Ms Wells had mentioned febrile convulsions to him, he believes he would have taken a different approach and moved her into a cubicle for monitoring. Therefore, while he did not recall the exact words used in the conversation, he did not believe the words 'febrile convulsion' were mentioned and he also said she certainly was not having a febrile convulsion when he went to see her.[52]

58. Dr Teo did not have available to him the hard copy file with the triage assessment information on it, as it had not yet been created by Ms Lytwyniw. He could have looked up the information on EDIS, but he said it was time consuming and he felt it was quicker just to go and speak to her and do an assessment.[53]

59. Dr Teo gave evidence he went straight over to Aishwarya and her parents armed only with the statement from Ms Wells that Aishwarya's mother was worried about white spots in her eyes. As he had not seen her triage information, he was unaware of her presenting history and other symptoms of diarrhoea, vomiting, feeling weak and cool hands.[54]

60. Dr Teo said he introduced himself to Aishwarya's parents and said words to the effect that the ward clerk had told him they were concerned about Aishwarya's eyes. When he approached them, Aishwarya was lying on the waiting room chair with her head resting on her father. Aswath recalled that she was very tired and struggling to be able

[49] Exhibit 1, Tab 13.
[50] Exhibit 2, Tab 40 [17].
[51] T 178; Exhibit 1, Tab 13 [106].
[52] T 195 – 196, 208.
[53] T 178 – 179,
[54] T 179 – 180.

to raise her head.[55] It appears on the CCTV footage that her head remained resting backwards on her father for the time that Dr Teo reviewed her.

61. Dr Teo examined Aishwarya by looking at both her eyes, but he did not do any further examination aside from her eyes. Dr Teo didn't have a torch with him or any other tools that would ideally be used for such an assessment, but he said he didn't think it was necessary at this point. From viewing the CCTV footage it is clear he does not touch her at any stage, but just looks very briefly at her eyes. Dr Teo said he saw there were two areas of white/opaque discolouration to Aishwarya's right iris that were oblong shaped.[56] He didn't notice anything else unusual about her eyes, such as yellowing. Dr Teo had never seen anything similar in a child's eyes before and it did not suggest anything in particular to him in terms of a diagnosis.[57]

62. Aswath recalled in his statement that Dr Teo had a brief look at Aishwarya and "barely made eye contact with us."[58] At the time, Aishwarya's parents did not realise he was a doctor and thought he was a nurse, although Dr Teo gave evidence he had a badge on his scrubs saying that he was a doctor and his usual practice was to introduce himself to patients and their parents. Aishwarya's parents recall Dr Teo did not touch Aishwarya or do any medical observations and he barely spoke to them before leaving.[59]

63. Their recollection of the interaction largely matches the CCTV footage, which shows Dr Teo reviewed Aishwarya for a total of less than 20 seconds.

64. Dr Teo agreed in evidence he did not speak directly to Aishwarya and his interaction with her parents was "a very brief interaction."[60] He said his assessment was "quite a focussed one"[61] and he did not ask them any questions. Dr Teo agreed that it is best practice to spend more time with the family of a child and explain what he is doing and communicate with them, but he explained at the time he felt the pressure of needing to see other patients and noted the fact that he was not intending to do a full assessment at the time.[62]

65. Dr Teo said in evidence that if he had known the information about Aishwarya's gastrointestinal symptoms and cool hands, rather than just believing she had an issue with her eye, he would have physically examined Aishwarya and taken a bit more of a history. Dr Teo agreed in questioning from me that, even if he had asked some very basic questions about whether she had sustained an injury to her eye such as from being struck or whether there was another cause, this might have assisted him to head down that path. However, without that information, he believed it was just an issue with her eye, and although they were unusual, there was nothing alarming about the

---

[55] Exhibit 1, Tab 11.2 and Tab 12.2.
[56] Exhibit 1, Tab 13.4.
[57] T 180 – 183, 209.
[58] Exhibit 1, Tab 11.2, [53].
[59] Exhibit 1, Tab 11.2 and Tab 12.2.
[60] T 184.
[61] T 184.
[62] T 184 – 185.

white patches he had seen in her eye and he felt she could wait for a full assessment, including a comprehensive eye examination.[63]

66. Accordingly, after seeing Aishwarya for less than half a minute, Dr Teo left her and went back to seeing his other patients in Pod C that were ahead of her in the queue, with the expectation that Aishwarya would have observations taken by a nurse and then be reviewed again by a doctor in due course.[64]

67. Dr Teo did not make a note of his examination of Aishwarya. He indicated it is not unusual in a busy ED to not make notes immediately and he did not think there was anything significant enough about the white spots he had seen in her eye to require adding a note to what he assumed had already been included in the triage form. Nevertheless, he accepted that it would have been best practice for him to make a note as soon as practicable after his examination. However, Dr Teo also commented that it is often a struggle to find a free computer to enter those notes, even when there is time to do so.[65]

68. Although he did not make a note at the time, Dr Teo stated Aishwarya was not grunting in pain when he saw her and he was unaware that she had a temperature. He indicated that he was aware of the sepsis pathway, but in his brief interaction with Aishwarya, he did not see any signs that suggested to him that she might be suffering from an infection.[66] He did, however, concede in questioning that her head appeared "floppy"[67] in the CCTV footage and it is possible that she could have been grunting in pain, but just not at the time of his brief interaction with her.[68] Dr Teo also agreed that, based upon the vital signs taken by Nurse Vining shortly after his brief assessment, Aishwarya would have met the criteria to place her on the sepsis pathway, although her symptoms could also have been consistent with a gastrointestinal illness.[69]

69. Dr Teo's examination was the second missed opportunity for a member of PCH health staff to recognise that Aishwarya was very unwell, becoming septic and required urgent medical treatment. The initial triage score set the early timeframe for priority for medical assessment, but anyone could escalate the care if it became apparent it was needed, and Nurse Taylor gave evidence it is a common occurrence.[70] Dr Teo could have taken steps to have Aishwarya's treatment prioritised if he had realised that it was necessary. Unfortunately, he did not as he did not have a full picture of her presentation or the time to assess her fully, so he did not appreciate that she was critically unwell.

70. Dr Teo accepted that in hindsight it would have been preferable not to limit his examination to the single issue, but at the time he felt he was being efficient and trying to deal with an issue quickly so that he could get back to his allocated task of seeing

[63] T 185, 186.
[64] T 185, 210.
[65] T 193; Exhibit 1, Tab 13 [131] – [134].
[66] T 187 – 189, 199; Exhibit 1, Tab 13 [142].
[67] T 200.
[68] T 199.
[69] T 201, 210.
[70] T 108 – 109.

his allocated patients in order in Pod C on a busy shift.[71] Dr Teo also accepted that if he had slowed down, he might have given himself an opportunity to speak to Aishwarya's parents and assess Aishwarya a bit more closely, which might have helped him to realise she had more developing than simply an issue with her eye. In that way, he also accepted that this was a missed opportunity to change the path of Aishwarya's care that night and start earlier intervention.[72]

71. Dr Simon Wood, the Executive Director of Medical Services at CAHS, indicated in his overarching report and in his evidence at the inquest that CAHS agrees that Dr Teo should have taken these extra steps, as the additional information may have prompted a more thorough evaluation of Aishwarya. However, he also noted that Dr Teo was a very junior doctor, with this event occurring during his first rotation as a paediatric registrar. With increasing clinical experience, he might have been expected to take a more holistic approach rather than focussing on a single complaint, but at the time he was busy and so he focussed on only the one aspect he believed he was being asked to assess.[73]

72. Dr Teo fully cooperated with the inquest process, providing a very helpful and detailed statement at an early stage that greatly assisted the Court in its preparation. He made a frank admission that, in hindsight, there was more he could have done in the way of follow up questions with Aishwarya's parents that might have assisted him to identify that there was something else wrong with her. As it was, he focussed only on her eye, and there was nothing of significance that caused concern. Although bacterial sepsis can present with an infection of the eye, the evidence in this case did not appear to support the conclusion that this was what was visible in Aishwarya's eyes at the time. Dr Teo expressed regret and has clearly learned from this experience.

73. I note that Dr Teo was also described by one of his senior colleagues during the inquest as "one of the kindest doctors"[74] they had worked with and they noted he "is a very sensible, intelligent and compassionate"[75] doctor. There is no suggestion he missed the warning signs because he didn't care enough to look for them. It is just another indicator of stressed and busy staff who are trying to multi-task in a busy ED.

OBSERVATIONS TAKEN BY NURSE VINING

74. A minute or so after Dr Teo left, at 5.42 pm, Aishwarya's mother approached the administration desk once again and again spoke to Ms Wells and the other ED clerk at the desk, Ms Lesha Lytwyniw. Ms Lytwyniw was allocated to Pod C and was located at the Pod C administration desk in the Pod C waiting area, in the same place as Ms Wells. She had been present during the first conversation between Ms Wells and Prasitha, but did not join in that conversation.

---

[71] T 212.
[72] T 213.
[73] T 670 – 671. Exhibit 3.1, p. 17.
[74] T 364.
[75] T 364.

75. Ms Wells recalled when Prasitha approached her for the second time, she could tell that Prasitha "was really upset about Aishwarya."[76] Ms Wells perceived the conversation as very awkward and said she felt very uncomfortable as it seemed like Prasitha was right in her face, although she concedes from watching the CCTV footage there was a desk separating them. Ms Wells remembers Prasitha said words to the effect that Aishwarya "had a fever; that she was cold; that she had 'cloudy eyes' and wanted to see a doctor."[77] Ms Wells did not recall Aishwarya's mother saying that Aishwarya was getting worse or that her condition was deteriorating, and when Ms Wells looked at Aishwarya, it looked to her like Aishwarya was just waking up and getting comfortable.[78]

76. Ms Wells was aware that Dr Teo had just been to look at Aishwarya only a minute or so before, so she did not go and get a doctor again. Instead, she told Aishwarya's mother that she would go and get the wait-room nurse. Ms Wells went to the Nurse Coordinator's desk and was informed that Registered Nurse Tahnee Vining was the nurse allocated to the waiting room. Ms Wells went and found Nurse Vining and told her that Aishwarya's mother was worried that her child had 'funny eyes'. Ms Wells remembered Nurse Vining told her she would come out and see Aishwarya shortly. Ms Wells spoke to another staff member and then headed back to her desk, meeting Ms Vining and the student nurse in the doorway as they were walking into the waiting area. Nurse Vining asked her to point out Aishwarya and her parents, which she did. Ms Wells recalled Aishwarya was sitting up at that stage and she saw Nurse Vining and the student nurse approach her while Ms Wells returned to her desk.[79]

77. In the meantime, Aishwarya's mother had been called to approach the administration desk again and provide some details, including her Medicare card, to the other ward clerk, Ms Lytwyniw. Ms Lytwyniw gave evidence that she had not been able to find Aishwarya in the system, so she wanted to see her Medicare card to check the correct spelling of Aishwarya's full name, in case it had been entered incorrectly. She established Aishwarya was a new patient, so Ms Lytwyniw registered Aishwarya's details into the system and created a record for her as a new patient. She obtained the relevant information to do so from Aishwarya's mother. This was completed at 5.52 pm, and from this stage onwards there was now a physical hard copy file for Aishwarya. Ms Lytwyniw finished her shift not long afterwards and did not have any further interaction with the Chavittupara family.[80]

78. As Aishwarya's mother and Ms Lytwyniw were finishing up, Nurse Vining and the student nurse approached Aishwarya and began to talk to Aishwarya and her father. They were then joined by Prasitha.[81]

79. Nurse Vining completed her nursing studies in 2015 and began working soon after, although her graduate training was then interrupted for personal reasons. She was employed in the PCH Outpatients Department in January 2019, where she then

---

[76] Exhibit 2, Tab 40 [19].
[77] Exhibit 2, Tab 40 [20].
[78] Exhibit 2, Tab 40 [22].
[79] Exhibit 2, Tab 40 [24] – [29].
[80] T 155, 167; Exhibit 1, Tab 41.
[81] T 155, 167; Exhibit 1, Tab 41.

completed her RN graduate training program. Nurse Vining commenced working in the PCH Emergency Department on 10 January 2020. Therefore, on 3 April 2021, Nurse Vining had been working as a registered nurse in a graduate program for 12 months and as a registered nurse in the ED for 15 months. She described herself as a junior nurse at that time.[82]

80. Nurse Vining gave evidence that she had never knowingly treated a patient with confirmed sepsis at that time, although she had been involved in treating patients with possible sepsis, who would then go on to a ward for further diagnosis and treatment.[83]

81. In the six months leading up to April 2021, Nurse Vining indicated that "the ED at PCH had been extremely busy and the workload was frequently overwhelming."[84] She was aware complaints had been raised by senior nursing staff with the PCH executive team about nursing workloads, and the related concerns about patient safety, but the issues remained unresolved.[85]

82. On this particular day, Nurse Vining had been allocated as the Waiting Room Nurse, which had been introduced at Princess Margaret Hospital prior to the transfer to PCH. Nurse Vining indicated in her statement that she was not aware at the time of any policies or guidelines for the role of Waiting Room Nurse (WRN). Prior to the inquest, Nurse Vining was assisted by the PCH ED Clinical Nursing Staff Development Nurses to find a policy for the role of the WRN, but she said she had never seen it before and it was in a locked file in the computer system only accessible by the ED Clinical Nurse Specialists, so she did not have access to it when performing the role.[86]

83. Without reference to the policy, Nurse Vining said she was trained by senior nurses to understand that the key responsibilities of the WRN were to perform initial assessments and start simple interventions to assist with workflow. The WRN had the responsibility to care for all the patients in the waiting room, which could be up to 40 patients at that time. In addition, the WRN would also be allocated to the resuscitation team and would regularly be instructed to leave the waiting room unattended if required to assist with other patient interventions in the assessment pods.[87]

84. The WRN role was, without question, an extremely busy role with competing demands. Nurse Vining lists at least 13 different duties that could be expected to be completed by the WRN in any given shift. There was no other allocated nurse to assist with the patients in the waiting room at that time. While there was an ED Clinical Nurse Specialist overseeing the whole ED, they were not readily available to assist the WRN, other than in an emergency.[88] Nurse Vining gave evidence that another big role for the WRN was reassuring patients and their carers and explaining why there was a delay in being seen, noting that if a carer chose to leave without their child being seen there was a long process involved in advising the shift coordinator and trying to

---

[82] T 229; Exhibit 1, Tab 15.
[83] T 229.
[84] Exhibit 1, Tab 15, [27].
[85] T 229 – 230; Exhibit 1, Tab 15.
[86] T 233.
[87] Exhibit 1, Tab 15.
[88] Exhibit 1, Tab 15.

convince the parents or other carer to stay and wait for the child to be seen, and ultimately documenting what had occurred if they maintained their right not to wait and left the hospital.[89] Nurse Vining stated that as a result of these competing demands, her understanding at the time was that the WRN role was considered very challenging and "was seen as one of the least desirable roles to be allocated"[90] by many of the nursing staff.

85. On 3 April 2021, Nurse Vining had been allocated the role of WRN and 'resus runner' for the resuscitation team (a newly introduced role due to COVID PPE requirements)[91], and she was also precepting (supervising/mentoring) a long-term nursing student who was on her fourth shift at the PCH ED. Although one might think having an extra pair of hands might be of benefit, Nurse Vining explained that this was actually an extra commitment on the night, as she had to explain presentations, rationale for clinical decision making and treatments for the education of the nursing student. Further, Nurse Vining was expected to be the 'float nurse' for the pods, helping with medications and procedures as necessary. At the start of her shift, she was also required to check and restock the resuscitation bay equipment trolleys.[92]

86. Performing these various roles meant that geographically, Nurse Vining was moving from the waiting room to the different pods throughout the shift. This required her to often leave the waiting room unattended for long periods, particularly when assisting with a resuscitation call, which could occur at any time and required her to urgently attend.[93]

87. Nurse Vining started her shift at 1.00 pm and was due to work until 9.30 pm, which was a standard shift. It was a busy afternoon and Nurse Vining and the student nurse had been dealing with what she considered to be "an unusually busy and noisy waiting room due to bed blockages and a high level of patient presentations."[94] Nurse Vining understood there were the appropriate number of nurses on the afternoon shift, as set by the PCH executive team, but she noted ED nursing staff had been challenging this number for some time. In addition, at 5.45 pm, one nurse from the resuscitation team went home sick, so even on the usual rostered number, they were then one person down and Nurse Vining's role in the resuscitation team was upgraded from resus runner to 'role 1 airway', with no replacement for the resus runner role.[95]

88. Nurse Vining estimated that on average during this shift there would have been at least 20 patients waiting in the waiting room area at any given time. She said it was "impossible"[96] for her to provide adequate care to that many patients as the WRN, or even to adequately observe and monitor them to see if their situation changed or they showed any signs of deterioration.[97]

---

[89] T 235.
[90] Exhibit 1, Tab 15, [55].
[91] T 232.
[92] T 231, 233; Exhibit 1, Tab 15.
[93] T 232.
[94] Exhibit 1, Tab 15, [67].
[95] T 232; Exhibit 1, Tab 15.
[96] T 236.
[97] T 236 – 237.

89. When Ms Wells approached Nurse Vining, she had just completed a patient nurse assessment and was entering nursing documentation on a computer. Nurse Vining recalled that Ms Wells approached her at approximately 5.45 pm and informed her that there was a father in the waiting room who was worried about his child's eyes, which the doctor did not see before. Nurse Vining stated her "first impression at that point was there was a patient in the waiting room who had been seen by a doctor, and that a new symptom had developed, specifically with her eyes.[98] However, soon after speaking to Ms Wells, Nurse Vining checked EDIS and could not see an entry where a doctor had reviewed a patient who was still in the waiting room. This is because Dr Teo had not made an entry in EDIS.[99]

90. As Nurse Vining could not identify the patient from EDIS, she asked Ms Wells to identify the patient to her in the waiting room. The CCTV footage shows Ms Wells pointing out Aishwarya and her parents to Nurse Vining at 5.49 pm. Nurse Vining went and spoke to Aishwarya's father. I note at this stage that, based upon her triage score and the number of patients waiting, Aishwarya would not have been next in line to be seen by Nurse Vining at that time. However, given a family member had raised a concern, Nurse Vining prioritised seeing her out of order, which was appropriate. Nurse Vining said her plan was to either simply provide reassurance to Aishwarya's family, noting there were a large number of other patients waiting, or assess Aishwarya, depending on what she observed and the nature of the concerns.[100]

91. Nurse Vining recalled that she approached the family and introduced herself and the student nurse. Aswath told Nurse Vining he was concerned about Aishwarya's eyes and Aishwarya then turned her head and looked at Nurse Vining, so Nurse Vining could assess her eyes. Nurse Vining recalled she did not see anything concerning but did notice her irises looked a bit discoloured and there were flecks of some type. Based on her knowledge at the time, it did not indicate anything for her to be concerned about. Normally, she would become concerned if she noticed jaundice of the sclera or generalised clouding of the eyes, but these clinical observations were not apparent at this time and Nurse Vining was uncertain of the significance of the flecks in the irises.[101] In her evidence, Nurse Vining indicated that she had later seen Aishwarya's eyes during the resuscitation and observed that her eyes appeared yellow and jaundiced, which was definitely not what she observed when she saw Aishwarya in the waiting room.[102] Nurse Vining asked Aishwarya's parents if her eyes normally looked different, and they said it was not normal for her.

92. Aswath then said that Aishwarya had cold hands and mentioned a few other things. It was apparent to Nurse Vining that he was very concerned.[103] Nurse Vining stated she originally planned to simply reassure the family, but due to Aishwarya's father's level of concern, she decided to prioritise Aishwarya's assessment ahead of approximately 10 other patients in the waiting room who had been waiting longer and were ahead of Aishwarya in priority. Nurse Vining went and found a portable observation monitor

[98] T 237 - 238; Exhibit 1, Tab 15, [73].
[99] Exhibit 1, Tab 15.
[100] T 234, 238.
[101] T 239; Exhibit 1, Tab 15.
[102] T 240.
[103] T 239.

and used a Pod C computer to read Aishwarya's presenting triage history off EDIS, before donning gloves and returning to assess Aishwarya at 5.50 pm. They were joined around this time by Aishwarya's mother, who had finished providing information to Ms Lytwyniw.[104]

93. The nursing assessment commenced at about 5.50 pm and took approximately 14 minutes in total, including the student nurse weighing Aishwarya at the end. Based on my observation of the CCTV footage, Aishwarya's parents look visibly concerned during the assessment. By the time Nurse Vining and the student nurse leave them at just before 6.05 pm, Aishwarya appears on the screen to be quite floppy with her head lolling while her mother moves her. She then lays down across her mother, with her head in her mother's lap.

94. Nurse Vining stated that at the time she started the assessment, she was aware Aishwarya had been triaged as a category 4 on EDIS and was streamed to Pod C, which is the low acuity section. Based on what she saw on EDIS and the fact Aishwarya had only been in the waiting room for about 15 minutes at that stage, Nurse Vining assumed that there was a miscommunication and that a doctor had not actually seen her, and the reference might have been to a triage nurse.[105]

95. Before the Court received the statements of the various PCH staff involved, I had thought that perhaps Dr Teo's conclusion that Aishwarya's case was not urgent might have contributed to the decision-making that followed. However, given Nurse Vining's evidence, it would seem this was not the case, as she did not become aware Dr Teo had actually seen Aishwarya until well after her death.[106]

96. Nurse Vining gave evidence she asked Aishwarya's parents what had been happening and Aswath said that Aishwarya had been unwell since Friday morning, with fevers and some vomiting. She seemed better Friday night but then she continued to be unwell on Saturday and started having diarrhoea. In the afternoon they became quite concerned because her hands had become very cold, and that was why they had come to the hospital.[107]

97. Nurse Vining began to perform a set of observations by connecting the pulse oximeter probe onto Aishwarya's finger. Aishwarya followed Nurse Vining's verbal cues and independently lifted her left arm and hand towards Nurse Vining to allow her to do this, but did not say anything in response. At some stage Nurse Vining clarified with Aswath that Aishwarya spoke English, to confirm she understood her, and then assumed that Aishwarya was just shy.[108]

98. Aishwarya was sitting upright and unsupported in her father's lap at this stage, although he was repositioning at times, which Nurse Vining interpreted as him trying to take care of her. Nurse Vining then took Aishwarya's blood pressure, which was 114/103, and assessed her respiratory rate, which was 44 breaths per minute. Nurse

[104] T 238; Exhibit 1, Tab 15.
[105] T 241; Exhibit 1, Tab 15.
[106] T 241; Exhibit 1, Tab 15.
[107] T 240.
[108] T 242.

Vining then took Aishwarya's temperature, which read 38.8°C. Nurse Vining indicated that she wrote these results on her arm as Aishwarya didn't have patient notes yet and the nurses also don't generally carry patient's paperwork into rooms due to COVID restrictions.[109] Nurse Vining then entered the information in the Emergency Department Nursing Assessment (EDNA), which is on the back of the triage form, after the assessment.[110] Nurse Vining gave evidence none of these readings were concerning to her at face value, but she would have been guided by the Paediatric Acute Recognition and Response Observation Tool (PARROT) chart to determine if any were high for a child of Aishwarya's age. That did not occur until sometime after the assessment, as Nurse Vining was called away to perform other tasks before she could enter Aishwarya's observations into the PARROT chart.[111]

99. The PARROT chart clearly states that if a temperature is above 38.5° a local sepsis process should be considered, but Nurse Vining was unaware of that prompt until she completed the chart as it was a relatively new chart that had only recently been introduced into the ED. Nurse Vining did agree that even without the benefit of the PARROT chart, she was aware that Aishwarya's temperature was above the normal temperature for a child of 37.5°, so she was febrile (had a fever). However, Nurse Vining gave evidence she had been taught that fever alone was not something that always needed to be escalated as it was a common feature of most presentations to the Emergency Department.[112]

100. Nurse Vining could not get a reading of Aishwarya's heart rate and oxygen saturations as the pulse oximeter machine was not working, so she auscultated her chest to get a manual heart rate and noticed that Aishwarya's heart was beating fast but regularly and her lungs were clear. After trying the machine again, Nurse Vining got the student nurse to get another machine, which immediately provided readings. The reading on the monitor indicated Aishwarya's oxygen saturation was 98% and her heart rate was 150 beats per minute. Nurse Vining indicated the oxygen saturation result was normal and the heart rate was high, but she was aware that it is very common for patients to present tachycardic (with a high heart rate) when they had a fever, so she was not concerned.[113]

101. Aishwarya's father had asked a few questions about the readings, and he recalled that he was told Aishwarya's heart rate was higher than normal, but the nurse did not explain why that might be or that it was anything to be concerned about. Nurse Vining also told them that Aishwarya's blood pressure was normal. Prasitha recalled Nurse Vining also told them that Aishwarya's temperature was a bit high.[114] They had understood that there was an issue taking Aishwarya's oxygen levels, which Aswath recalled the nurse thought initially might be because of Aishwarya's cold hands, and she then went and got another machine. Aswath believed Nurse Vining still could not get a reading with the new machine, but Nurse Vining was very clear in her evidence

[109] T 242.
[110] T 244; Exhibit 1, Tab 21.2.
[111] T 245, 247.
[112] T 245, 277.
[113] T 246 - 247.
[114] Exhibit 1, Tab 11.2 and Tab 12.2.

that she got a successful reading within seconds on the new machine.[115] It would seem this was simply not understood by, or communicated to, Aishwarya's parents.

102. Nurse Vining also said she performed a capillary refill check, which was a normal number of under two seconds. This result was not entered in the EDNA chart itself, as Nurse Vining said she understood at the time that that neurovascular assessment part of the EDNA form, which included a vascular and capillary refill check, was only completed for patients presenting with neurovascular injuries, which did not apply in this case. Nurse Vining gave evidence that part of the form has now been removed and there is just a central capillary refill section, with the neurovascular chart now separate.[116]

103. During the time Nurse Vining was taking the observations, she observed that Aishwarya was quiet but alert and responsive, obeying her commands throughout her assessment. Nurse Vining commented that it is not uncommon for paediatric patients to be quiet during an assessment as the ED is a strange environment for them. Nurse Vining stated that she did attempt to establish whether this was Aishwarya's normal baseline or whether her quiet state was part of the illness that had led to her presentation. Nurse Vining recalled that there was no mention by Aishwarya's parents during the presenting history of any concerns around an altered mental status or change in behaviour, other than Aishwarya was tired and sleepy. Nurse Vining remembered herself seeing that Aishwarya seemed tired and pale, but this was not concerning for her as it is expected for patients experiencing viral illness, fever, pain and dehydration.[117]

104. Nurse Vining recalled that there was no specific mention of pain during the assessment, other than the fact that her father said Aishwarya had a headache. However, she did acknowledge that she heard some brief grunting noises from Aishwarya about halfway through completing the assessment and she had made a note of this in the EDNA of Aishwarya "grunting in pain."[118] Nurse Vining said she had noticed that Aishwarya was making a "grunting, groaning type noise"[119] after she had finished auscultating, and was looking at the machine, but when she turned and came to listen again, it had completely stopped and she never heard it again. Nurse Vining stated she felt the grunting was not a consistent finding with the otherwise clear respiratory assessment, which is why she ticked 'nil' in the box related to grunting associated with respiratory distress.[120]

105. In terms of assessing Aishwarya's pain, Nurse Vining gave evidence that she used the FLACC (Face, Leg, Activity, Cry, Consolability) scale to assess her pain, which was not written on the EDNA form but is embedded in the PARROT chart. Based on that scale, she came to a score of 2 out of 10, noting that grunting is actually not listed in the scale but moaning is listed and she scored a 1 for that feature. Nurse Vining felt her headache was consistent with a generalised illness and also dehydration, and was

---

[115] T 246; Exhibit 1, Tab 11.2 and Tab 12.2.
[116] T 251 - 252.
[117] T 247 – 250; Exhibit 1, Tab 11.2 and Tab 12.2.
[118] Exhibit 1, Tab 21.2.
[119] T 249.
[120] T 249.

planning to give her Nurofen to see from there if that form of pain relief was effective or not.[121]

106. Nurse Vining was asked if her assessment would have changed if she had been told that Aishwarya had woken up on Friday morning with a sore leg and sore hands. Nurse Vining said she would have been more concerned as generalised body aches and severe, unexplained pain are more concerning symptoms, especially in relation to sepsis. However, she was not aware of these symptoms at the time.[122]

107. Aishwarya's parents did tell Nurse Vining about Aishwarya's cold hands. Nurse Vining recalled that she felt Aishwarya's hands and did note that her hands were cold, but in her experience "it is not uncommon for children that present with fever to have cold peripheries,"[123] so she was not overly concerned. Nurse Vining said she planned to treat the fever, pain and dehydration and then observe to see if it had helped.[124] Aswath recalled that one of the nurses told them that Aishwarya's hands were probably cold from the air conditioning, but she would inform the doctor. It's not clear if this statement was said to have been made by Nurse Vining or the student nurse, and Nurse Vining did not mention it and the student nurse was not called. I don't consider it alters the situation significantly in any event.

108. Nurse Vining gave evidence that since these sad events, she still sees patients quite regularly with cool peripheries when they have a fever and adopts the same practice of treating the fever and pain and reassessing from there, but she also escalates to a senior nurse quite promptly in those cases to ensure that she is "thinking the correct treatment pathway."[125]

109. It was put to Nurse Vining in questioning, similarly to a discussion with Dr Teo, that Aishwarya was "floppy" and could barely lift her head during the assessment. This was based on her parents' account and the CCTV footage. Nurse Vining's evidence was that she did not see this, and at the time of her assessment, Aishwarya was sitting upright in her father's lap with her head upright. Nurse Vining said if she had been attempting to do a set of observations on a floppy child, it would have very difficult, so she would have noticed.[126]

110. After finishing the assessment of Aishwarya, the student nurse weighed Aishwarya and provided the weight to Nurse Vining, who entered the information on the front triage part of the form. Nurse Vining and the student nurse then left to carry out other duties, with a plan for certain steps to be taken in terms of trialling Aishwarya on oral fluids and Nurofen to see if she improved. Nurse Vining gave evidence she didn't write this plan down in the EDNA chart as she "wasn't very well educated that we used the plan area" on the chart and also didn't have time because she got called away to Pod B to help with a blood collection, but she knew in her head the plan was to start an oral fluid trial, to administer an oral ibuprofen and to check her blood sugar level

[121] T 250, 274 – 275 .
[122] T 251.
[123] T 248.
[124] T 248.
[125] T 249.
[126] T 277.

because she had had so much diarrhoea and vomiting. She intended to initiate this plan within half an hour, but she was unable to, and instead she later handed over that plan to Nurse Wills when she went on her break.[127]

111. Nurse Vining gave evidence that when she was called away to Pod B, she thought the task she was going to do would only take about ten minutes. Nevertheless, she spoke to a Pod C Nurse, Laura Thompson and said, "Just so you're aware, I've just seen this Pod C patient. I was concerned about this and this. I now need to go to Pod B."[128] Nurse Thompson told her to put the information into the clinical comments on EDIS, which Nurse Vining then did before going to Pod B to assist. The note was made at 5.50 pm. It is brief and mentions Aishwarya's father's concerns about her eyes and cold arms and says that she reassured him and offered a blanket (as the waiting room is cold). It does not mention her plan to initiate a fluid trial, or any other aspect of her plan. Nurse Vining said that she didn't write it in as she didn't have time and thought she would be back soon to initiate it. In the end, the task in Pod B took more like 15 to 20 minutes, and Nurse Vining was then called to assist with a resuscitation, so she did not return to the waiting area for 55 minutes.[129]

112. Upon her return to the waiting room area, at 6.43 pm, Nurse Vining was told by the shift coordinator to go to tea straight away or she might not get the opportunity to do so. Accordingly, Nurse Vining gave a handover to Nurse Wells to initiate her plan with Aishwarya. Nurse Vining also completed the PARROT chart at this time and the clinical comments in Aishwarya's paperwork, before going on her tea break.[130]

113. Nurse Vining was asked whether filling in the PARROT chart prompted any concern about either sepsis or a more general need to escalate her care. She said it didn't as when she was putting in the observations, she could see Aishwarya was febrile and tachycardic and tachypneic (breathing rapidly). However, these were all consistent with fever or viral illness and her calculated score was a 2, so she wasn't concerned. In addition, she gave evidence she hadn't received a lot of education around the use of the relatively new PARROT chart and believed it was just a trial, so she relied on her knowledge of what to do from previous presentations. Nurse Vining said she had felt happy, after completing the chart, that the plan was still appropriate. She had not considered approaching a senior nurse and noted there wasn't one around at that time even if she had wanted to do so, but she also believed they would have simply confirmed that she was following the correct treatment plan at the time. Nurse Vining also said that if the PARROT score she calculated had been slightly higher as a 3 (had an additional score of 1 been added to her total of 2 to reflect high levels of parental concern), rather than a 2, she still would not have escalated to a senior nurse, as the practice in the PCH ED at the time was not to escalate scores of 1 to 3, only from 4 and above.[131]

114. Nurse Vining's evidence was that sepsis was not something that crossed her mind on this particular night as she was aware that Aishwarya was a previously healthy,

[127] T 253 - 254.
[128] T 255.
[129] T 255 – 257, 263; Exhibit 2, Tab 35.2.
[130] T 257 - 258.
[131] T 258 - 260.

immunised child who did not meet the high-risk criteria for sepsis. Her presentation suggested to Nurse Vining that Aishwarya was experiencing viral gastroenteritis, a very common presentation to the PCH ED, which is why her plan was to commence the oral fluid trial and ibuprofen.[132] Nevertheless, Nurse Vining agreed when it was put to her by counsel for Aishwarya's family that on 3 April 2021, looking back at all the symptoms that were present, she should have considered sepsis as a possible or suspected diagnosis but she didn't. Nurse Vining said if she had had the time to sit and look at the documents, she believes she could have had time to consider the sepsis diagnosis, while noting that even to this day the likelihood that the symptoms were more related to fever would be at the forefront of her mind, given the rarity of sepsis.[133]

115. The assessment by Nurse Vining was the third, and arguably the most significant, missed opportunity for a PCH staff member to recognise that Aishwarya was seriously unwell and potentially septic. This was the first time that vital observations were recorded that might point to this conclusion, and the clinical observations also began to point towards a sepsis pathway. However, those signs were not recognised. Nurse Vining said she did not have an opportunity to complete the paperwork, such as the PARROT chart, that might have helped her to identify this, nor to stay and observe Aishwarya and give her an oral fluid trial and analgesia to see if that was effective.[134] Nurse Vining gave evidence at the inquest that she believes if she had been present in the waiting room after the assessment and had the opportunity to finish the paperwork and continue and finish the interventions for Aishwarya she had planned to do, she "would have been able to recognise her deterioration and recognise the severity of her illness."[135] She could have then escalated her care to a doctor. However, due to the competing demands placed upon her that required her to be in many different places at once, she was unable to do so.[136]

THE NEXT HOUR

116. After Nurse Vining and the student nurse left, Aishwarya's parents continued to wait. No one from PCH interacted with Aishwarya's parents for the next half an hour or more. Aishwarya's parents can be seen on the CCTV footage trying to make eye contact with staff members as they walked by, but no one acknowledged them. They can also be seen reassuring and comforting Aishwarya, while looking increasingly worried as they talked to each other. At some point, Prasitha asked one of the staff when Aishwarya would be seen, and she was told that there was an emergency, and the doctors were busy with that patient. She was told a doctor would have a look at Aishwarya when it was their turn.[137] Prasitha stated she felt that their concerns were ignored and not taken seriously.[138] Aishwarya continued to get worse while they waited.

[132] T 286.
[133] T 280.
[134] T 250.
[135] T 247.
[136] T 265 – 266, 280.
[137] Exhibit 1, Tab 11.2.
[138] T 23.

117. At 6.39 pm, Aishwarya's mother approached the PCH staff at the administration desk again. Ms Rebecca Newton-Cremers had replaced Ms Lytwyniw and she was at the desk along with another ED clerk, Mr Dhanush Vijayaraghavan. Prasitha seemed hesitant on her approach, as seen on the CCTV, but still approached the desk and spoke to Mr Vijayaraghavan, who was generally described as the 'man with the clipboard.' It can be seen from the footage that Mr Vijayaraghavan checked the computer at the administration desk and then said something to Prasitha before he walked away and she returned to her husband and daughter. Mr Vijayaraghavan couldn't remember the details of their discussion but he believes it related to how much longer the wait might be and he then looked at the computer to try to estimate the approximate wait time for people with her daughter's triage category.[139] Aswath recalled that they were told there was one other person to be seen and then it was their turn.[140] Mr Vijayaraghavan recalled walking past both parents and observing them and noticing that their parental concern for Aishwarya was increasing, based upon how they were holding her, but he had no further contact with the family.[141]

118. Ms Newton-Cremers had not had any interaction with Aishwarya or her family at this stage, but she recalled she looked over and could see Aishwarya looked limp and her father was holding her. Ms Newton-Cremers stated she became concerned from what she observed. It is clear from the CCTV footage that she then spoke to Nurse Caitlin Wills around this time, although Ms Newton-Cremers could not recall the subject of the discussion or whether it involved Aishwarya.[142]

119. Nurse Wills was not noticeable on the relevant part of CCTV footage before this time, but she had started her shift at 1.00 pm and was due to finish at 9.30 pm, like Nurse Vining. Nurse Wills was excused from giving oral evidence at the inquest for personal reasons, so her account is solely based upon the statement she provided, which was read into evidence.

120. For that shift, Nurse Wills had been allocated the role of registered nurse Pod C, being the low acuity area in the ED at the time. Nurse Wills also recalled the shift was quite busy and then one nurse went home early sick. There were a lot of high acuity patients waiting, and there were also a high number of patients allocated to Pod C. One of the Pod C children, who had been there since the start of Nurse Wills' shift, required IV fluids, which caused additional work and needed extra equipment. This was all in the context of heavier workloads in the ED since 2020, with those concerns continuing in April 2021.[143]

121. In relation to Aishwarya, Nurse Wills stated that she had no detailed knowledge of Aishwarya until around 6.45 pm, although she "had a vague awareness of a child in the department whose father was concerned about his child's eyes and cold hands"[144] as an entry had been made by Nurse Vining in EDIS.

---

[139] T 303; Exhibit 2, Tab 43.
[140] T 19.
[141] T 304; Exhibit 2, Tab 43.
[142] Exhibit 2, Tab 42.
[143] T 310.
[144] T 311.

122. At 6.45 pm, Nurse Wills received a patient handover from Nurse Vining at the administration desk. Nurse Vining pointed out Aishwarya to Nurse Wills and was told there were other children ahead of her but that Nurse Vining had done an assessment as Aishwarya's father was concerned. Nurse Vining told Nurse Wills that Aishwarya was tachycardic and febrile and seemed to be uncomfortable, and her parents remained concerned. Nurse Wills recalled she was also told a doctor had looked at Aishwarya in the ED, which is slightly inconsistent with Nurse Vining's evidence that she had come to believe that the reference to a doctor seeing Aishwarya was an error. Nurse Wills was told by Nurse Vining that her plan was to give ibuprofen and start a fluid trial. There was no suggestion at that time that there was anything particularly concerning about Aishwarya's situation, which is consistent with Nurse Vining's evidence. Nurse Wills stated the fact that her parents were concerned was not unusual for a child in the PCH ED.[145] After the handover, Nurse Vining and the student nurse then quickly left the waiting area to go on their tea break.

123. On the CCTV footage, Aswath can be seen picking Aishwarya up and holding her. Both parents look around at staff, but there was no acknowledgement or contact with any staff member. Aswath then put Aishwarya back down on the couch, now in a seated position, and held her hand while Prasitha rubbed her chest.

124. Aswath stated that although he was also very worried about Aishwarya the whole time they were in the waiting area, he was mindful they needed to wait their turn. As more time passed, they could see Aishwarya was getting worse and he and his wife were becoming increasingly worried for her.[146] They were also "worried about being kicked out of the hospital for being rude,"[147] so they tried to remain calm and respectful, but were still trying to pass on their concerns to staff. Similarly, Prasitha was worried and stressed about the long wait time, but was conscious of the sign they had seen indicating "abusive behaviour will not be tolerated."[148] She did her best to convey her concerns to staff, but felt ignored. Ms Newton-Cremers recalled that both parents were polite and quiet, which is consistent with their attempts to remain courteous and respectful despite their increasing concerns.[149]

125. Nurse Wills can be seen on the CCTV footage at 6.53 pm walking down a corridor past the family and Prasitha appeared to move as if she intended to approach her, but Nurse Wills did not stop and walked out of view into the other ED area. Prasitha then returned to Aishwarya and sat down again. Aishwarya's parents continued to look around, as they had been for most of the time, appearing to be trying to catch a staff members' attention.

126. Nurse Wills stated she had prioritised her duties and care to be provided to the waiting Pod C patients after speaking to Nurse Vining and at that stage, she had a patient with suspected internal bleeding who was of concern, as well as another small child with a

[145] T 311.
[146] T 18 - 19.
[147] T 19.
[148] T 22.
[149] Exhibit 2, Tab 42.

high fever and concerns regarding convulsions. She went to complete some duties in relation to these children before going to see Aishwarya.[150]

127. Nurse Wills is seen walking down the corridor reading a file at 6.55 pm. Shortly after, at 6.57 pm, Aishwarya's mother approached the administration desk again and spoke to Ms Newton-Cremers for the first time. Ms Newton-Cremers can be seen on the CCTV footage checking her computer and gesturing while looking at the screen. It appears she was telling Aishwarya's mother that there is a queue and Ms Newton-Cremers confirmed in her evidence this is what she was doing. She recalled that Prasitha asked her words to the effect of 'where is the nurse and when will my daughter see a doctor?' and she explained to her the way the waiting room worked in terms of selecting patients to be seen next and that is was always the sickest child seen first. Ms Newton-Cremers recalled Prasitha appeared to accept what she had said as she left.[151] Aishwarya's mother then returned to her seat and the family continued to wait.

128. Around this time, both of Aishwarya's parents recalled that Aishwarya had started complaining that his eyes were dirty and telling them that she felt as though she was falling, even though she was lying down on the couch. Aswath sat her up next to him to prop her up. Aishwarya could barely speak and her speech was becoming faint. Prasitha stated that she knew at this stage that they couldn't wait any longer and that is why she had approached the desk again. Prasitha said she went up to the desk and begged for someone to come and look at Aishwarya, putting her hands together in a begging motion. Aswath recalled Prasitha also begged a passing nurse to look at Aishwarya. That is not reflected in what can be seen physically on the CCTV footage, but I have no doubt that Prasitha and Aswath were begging for help by this stage in a general sense, while trying to be respectful and non-confrontational towards staff.[152]

129. Ms Newton-Cremers perception was not that Aishwarya's mother was begging or imploring her to escalate Aishwarya's care, noting she was polite and calm, but she did understand that they were asking when Aishwarya would be seen and were concerned.[153] Both parents are also obviously anxious on the CCTV footage. Ms Newton-Cremers recalled that she made an entry in EDIS or spoke to a nurse about this interaction and the fact Aishwarya's parents were concerned, although there is no record in EDIS and she isn't seen speaking to a nurse at that stage on the footage. She does talk to Ms Wells, the other clerk.[154] Ms Newtown-Cremers said if she had felt that Prasitha was begging or imploring her to escalate Aishwarya's care, she would have gone and got a clinical staff member.[155]

130. As it was, Nurse Wills returned to the administration desk at about 7.01 pm. Ms Newton-Cremers spoke to Nurse Wills around this time. Ms Newton-Cremers stated that in this conversation, she recalling bringing Aishwarya's condition, and her own concerns, to Nurse Wills' attention, although this conversation is not mentioned by

[150] T 311 – 312.
[151] T 292, 296; Exhibit 2, Tab 42.
[152] T 19, 23.
[153] T 290; Exhibit 2, Tab 42.
[154] T 290.
[155] T 293.

Nurse Wills in her statement. It was not long after that Nurse Wills then went to see Aishwarya.[156]

131. When Nurse Wills had come to the administration desk at around 7.00 pm, she left a cup of something on the desk, which appears to have been some fluids for Aishwarya and she returned again at 7.04 pm with ibuprofen.[157] Shortly after, at 7.05 pm, Nurse Wills approached Aishwarya and her parents for the first time. Nurse Wills brought with her the medication and fluid that Nurse Vining had suggested as her initial plan. Aswath believed they had waited between one and two hours by this time, which is largely consistent with the medical records and CCTV footage, although it was closer to one and a half hours. Given their anxiety for Aishwarya, I'm sure it felt like a very long time to Aishwarya's parents.

132. Nurse Wills stated that Aishwarya was lying in her father's arms when she first approached and "had a blank stare."[158] Nurse Wills went to give Aishwarya the medicine, but Aishwarya was so weak that she couldn't even lift up her head to take it. Her parents tried to help her, but Nurse Wills told them not to assist. Both of Aishwarya's parents described Nurse Wills as "very rude"[159] and she appeared frustrated with Aishwarya for not cooperating.[160] Nurse Wills stated the reason she asked them not to help was so she could observe Aishwarya and see if she could do it herself as part of her assessment. This was not explained to them, so they were simply confronted by the rude way she spoke to Aishwarya and them.[161]

133. Nurse Wills stated that when Aishwarya was given the medicine and cup, she was unable to lift her arm to put the cup to her mouth and was unable to lift her neck. She immediately told Aishwarya's parents to wait and went to get a doctor. Nurse Wills approached Dr William Hollaway, an Emergency Department Consultant who is a specialist in Paediatric Emergency Medicine and General Paediatrics and had been working at PCH for many years. Nurse Wills stated she explained to Dr Hollaway that she wasn't sure what was going on, but she was concerned. She told him that Aishwarya was febrile and tachycardic, it seemed like she had gastro but she was also floppy, not responsive and had a blank stare.[162] Dr Hollaway immediately went with Nurse Wills to the waiting room to see Aishwarya.

BRIEF REVIEW BY DR HOLLAWAY

134. Dr Hollaway gave evidence that it was an extremely busy shift that night, that was outside the norm.[163] However, he was always happy to be approached by staff and he immediately came to review Aishwarya at Nurse Wills' request because it was clear she was worried about a patient.

---

[156] T 293; Exhibit 2, Tab 42.
[157] T 312.
[158] T 312.
[159] T 23.
[160] T 20.
[161] Exhibit 1, Tab 11.2, [67] and Tab 12.2, [25].
[162] T 312.
[163] T 317.

135. Dr Hollaway recalled that he had been told by Nurse Wills, in effect, that she was concerned for Aishwarya as Aishwarya was unable to raise her hand to take a dose of ibuprofen and she wasn't sure what was going on with her. He couldn't recall if he looked at Aishwarya's electronic triage statement prior to seeing her and he would not have had access to her hard copy medical notes at that stage.[164]

136. Dr Hollaway can be seen on the CCTV footage returning with Nurse Wills into the waiting room at 7.09 pm and approaching Aishwarya and her parents. When Dr Hollaway walked up to the family in the ED waiting room, Aishwarya was seated. He spoke to her parents and took a brief look at Aishwarya. He observed that she looked unwell, had difficulty supporting her head and had cool peripheries (hands and feet). Dr Hollaway wasn't certain how he assessed her cool peripheries, as he acknowledged that on the CCTV footage he didn't appear to touch her limbs, although he gave evidence it is very clear in his mind that he touched her at some stage and noted she felt very cool to cold. In his evidence, Dr Hollaway said he remembered Aishwarya seemed "particularly floppy,"[165] which can be a sign of sepsis but can also be the effect of having a high temperature or a sign of neurological disease. At the time, he suspected there would probably be a neurological cause but it was too soon to formulate any kind of differential diagnosis.[166] Dr Hollaway didn't feel alarmed at the time he first saw Aishwarya, although he appreciated she was unwell and required an escalation in care.[167]

137. Dr Hollaway asked that Aishwarya be moved into a bed in the main ED assessment area to allow for a full assessment.[168] He returned to the pods to try to find a bed for her. There were no available beds in Pod A, which was the non-respiratory section where she would ordinarily be placed, so instead he found a bed for her Pod B instead. Dr Hollaway said that his plan was to get Aishwarya into a bed and a doctor to start seeing her and take it from there, or if there were no other doctors available, he planned to see her himself. Dr Hollaway was then called away by another doctor to review an infant that they were concerned about, so he expected that nurses and a doctor (if available) would be taking care of Aishwarya in the interim.[169]

138. Dr Hollaway explained that at this stage he appreciated Aishwarya was unwell but he had not formed the view she was critically unwell or experiencing a life threatening emergency. He felt there "was a moderate degree of urgency at that point"[170] and he wanted her seen within 10 to 15 minutes at that stage, based upon what he knew and had seen. Dr Hollaway said he expected Aishwarya would be properly examined, placed on a bed and a repeat set of observations taken. That care could be performed by a nurse and didn't necessarily require a doctor to be present.[171]

---

[164] T 324, 342, 352; Exhibit 1, Tab 19.
[165] T 326.
[166] T 324 - 327; Exhibit 1, Tab 19.
[167] T 342.
[168] Exhibit 1, Tab 19.
[169] T 324 - 325.
[170] T 325.
[171] T 325.

139. Dr Hollaway had not made any kind of differential diagnosis at that stage, as he said it was too early without knowing her observations, and preferably repeat observations to show any trend in her clinical state.[172]

INITIAL CARE IN POD B

140. Nurse Wills recalled Dr Hollaway told her to find a room for Aishwarya. Aishwarya's father also heard Dr Hollaway tell Nurse Wills to bring Aishwarya in, but he didn't hear Nurse Wills say anything to him in response and she walked away from him. After a short time, he became frustrated and simply picked Aishwarya up in his arms and walked through to the assessment area in the direction Nurse Wills had walked. When he walked in to the assessment area, he felt from "the nurses' body language that they were all having a casual chat and were in no rush."[173] Aswath became very angry at this point, given the circumstances.[174]

141. Nurse Wills understood that Aishwarya's parents were very concerned and that Aswath was particularly distressed and angry. He commented that the nurses were "just talking" while she was trying to do a clinical handover with other nurses. She explained to the other nurses that Aishwarya was very unwell and her parents were very concerned. Nurse Wills perceived that Aswath was displaying aggressive body language and said she felt intimidated, but she continued to assess Aishwarya and encouraged her parents to sit and be calm while she did this with the assistance of the Pod B nurse, as she was concerned for everyone's safety.[175]

142. Around this time, Registered Nurse Sarah Hanbury, who was allocated to Pod B, became involved. Nurse Hanbury had been working in Pod B since 1.00 pm with two other nurses, but one had been required to provide one-to-one nursing care for a sick child and the other had been called away multiple times. Accordingly, often it was only Nurse Hanbury caring for the 13 children in Pod B, plus any additional children in the waiting room overflow for Pod B, during the shift. Nurse Hanbury was also allocated a role as airway nurse in the resuscitation team, as was one of the other nurses in the Pod B team. Nurse Hanbury had recalled it was busy and the morning staff had handed over "in quite a flurry." Waiting times only increased from thereon and Nurse Hanbury recalled there were significant delayed waiting times that night.[176] Nurse Hanbury commented that "you're only half doing everything"[177] in that situation and required the assistance of ward staff to come and get patients, which was very unusual and reflected how busy it was that night.[178]

143. Nevertheless, when Aishwarya was brought into the Pod B bed at 7.11 pm, Nurse Hanbury clicked on EDIS at the same time to confirm she was now her patient. Nurse Hanbury said she had just come back from a brief dinner break, having finally discharged or transferred all the children in her care, and after walking back in after

[172] T 364.
[173] Exhibit 1, Tab 11.2, [71].
[174] Exhibit 1, Tab 11.2
[175] T 312 – 313.
[176] T 370.
[177] T 370.
[178] T 370.

her ten minute break she immediately saw that she had been allocated a new Pod C patient in her section. Nurse Hanbury also said she wondered at the time why the patient had jumped "20 patients up the queue"[179] as she did not know at that stage that Dr Hollaway had ordered an escalation of her care. Nurse Hanbury saw Nurse Wills bringing the patient around and assumed it was the same one as on EDIS and approached them. Nurse Hanbury asked Nurse Wills why she was being allocated a Pod C patient and during the conversation they were joined by the other Registered Nurse in Pod B. The other nurse was still caring one-to-one for another patient and they had a brief conversation about the other patient and their medication, before the other nurse left and Nurse Hanbury returned her attention to Nurse Wills.[180]

144. Nurse Hanbury gave evidence it was apparent Aishwarya's parents were very concerned and their handover was very broken while Nurse Wills spent time talking to them as well as doing the handover. Nurse Hanbury said that she tried to clarify what additional information was available beyond what was recorded on the triage, such as headache and vomiting. There didn't seem to be a medication or observation chart or any other paperwork to hand over. Nurse Hanbury had noted that Aishwarya's father had carried her around into the bay, which she had thought was unusual for a 7-year-old child at that time of the evening, but was not aware there was any other kind of urgency at that stage. She didn't feel like she had received a handover as Nurse Wills was mainly talking to Aishwarya's father, who was expressing his concerns about Aishwarya, so Nurse Hanbury began to walk around and collect the equipment needed to do observations. As a result, neither Nurse Wills nor Nurse Hanbury was observing Aishwarya closely at this time.[181]

145. Nurse Hanbury said when she realised Nurse Wills, who was supposed to be doing the observations, remained distracted she decided to go in and speak to Aishwarya herself as she was responsible for her on EDIS. Nurse Hanbury said that at that stage, Pod B was the respiratory area and she wasn't sure how Aishwarya met the respiratory criteria, so she was trying to find out more.[182] She wasn't trying to take observations at that stage, as that was something Nurse Wills still planned to do, but Nurse Hanbury tried to do a clinical assessment simply from looking at Aishwarya. She said she grabbed Aishwarya's foot as she made her way around the bed and noticed it was cold. Nurse Hanbury then came up to the side of the bed and began speaking to Aishwarya.

146. Aishwarya was conscious but Nurse Hanbury thought Aishwarya seemed significantly less chatty than a normal 7-year-old. Nurse Hanbury could see she was breathing quite significantly faster than she would have expected and when Nurse Hanbury auscultated her chest it was clear there was no wheeze, so there was no obvious reason for Aishwarya to be breathing in that rapid way. Nurse Hanbury asked her if she was hot or sore, and Aishwarya appeared to give a delayed answer, which Nurse Hanbury found concerning as it appeared there was something neurological occurring.[183]

[179] T 382.
[180] T 372 – 373.
[181] T 373 – 376.
[182] T 383.
[183] T 376 – 377.

147. Nurse Hanbury noted that Aishwarya was dry mucosally and had very dry cracked lips, which was consistent with her faster breathing but still unusually dry, and her central refill was delayed. In Nurse Hanbury's eyes, Aishwarya appeared to be a child that was rapidly seeming more unwell and her concerns began to escalate. As a result, Nurse Hanbury left the room and approached the Nurse Shift Co-ordinator, Cathryn Davies. Nurse Davies was just about to go on her break, having handed over to a colleague. Nurse Hanbury told her she was concerned about Aishwarya. Nurse Hanbury said that at that stage, she was thinking they might need to move her into the resuscitation area as they needed more room to assess and treat her and to be prepared in case her condition worsened.[184]

148. Nurse Davies went immediately with Nurse Hanbury to the room where Aishwarya was lying and approached Aishwarya. Nurse Davies quickly noted that Aishwarya looked concerning, with hypertonic arms and legs and with yellowed/discoloured sclera (in her eyes). She presented as confused and Nurse Davies later described her as catatonic. Nurse Davies and Nurse Hanbury immediately discussed moving Aishwarya to the resuscitation bay, and then started that process.[185]

149. Aishwarya was wheeled out of the Pod B room on her bed and moved to the resuscitation bay. Aishwarya did not specifically require resuscitation at that stage, as she was still conscious and breathing, but it was apparent she required an urgent escalation of her care with a number of different people involved, and the resuscitation bay has more room for staff and equipment for that purpose.[186]

150. Nurse Wills returned to her duties at Pod C at this stage and did not have any further involvement with Aishwarya's care. She discovered at 9.00 pm that Aishwarya had died and stated that she was deeply upset by the news and broke down soon after.

RESUSCITATION ATTEMPTS

151. Aishwarya was brought into the resuscitation bay at around 7.30 pm. Dr Hollaway had heard the call over the Vocera communication system and came to ask if they needed help. He joined them as Aishwarya's bed was being wheeled into the resuscitation room. Dr Hollaway then led the resuscitation efforts as they were joined by other staff members allocated to the resuscitation team that evening.[187]

152. Dr Hollaway gave evidence he hadn't anticipated being called back so quickly but he appreciated that either something had changed or someone had been able to have a better look at her in the room. When he saw her, he "certainly had the impression she was sicker than [his] first glance at her in the waiting room."[188] The sudden change was a sign of a "very rapidly progressing disease."[189] Dr Hollaway acknowledged that

---

[184] T 377 – 378.
[185] T 377 – 378; Exhibit 2, Tab 38.
[186] T 378, 396.
[187] T 327, 379.
[188] T 343.
[189] T 343.

in hindsight, Aishwarya could have gone straight to a resuscitation bay, but when he first saw her she had not appeared that unwell.[190]

153. It was apparent to Dr Hollaway when he saw Aishwarya heading into the resuscitation room that her consciousness was altered, which was a sign of something going on in the brain. He felt it could be the beginnings or end of a seizure.[191] She was also hypotensive (low blood pressure), tachycardic and had a raised respiratory rate. That was a significant change from her early observations and Dr Hollaway noted that "children are able to maintain their cardiovascular status until very late in the piece with sepsis,"[192] which appears to have happened here. Dr Hollaway gave evidence he thought at this stage that Aishwarya had a severe infection and was wondering if there was an element of encephalitis going on with the infection, signifying a primary brain cause as the infection or secondary to the infection itself.[193] It was unclear at that stage where the actual infection was located.[194]

154. Dr Michael Hale, who was a paediatric critical care registrar at the time, was allocated to try and assess Aishwarya and he tried to engage her and obtain a focussed and clinical history. He asked her questions and got answers only intermittently, and those answers were single words, so he also began to engage with her parents to obtain information and try to work out if it was a language issue or something more. An issue was then identified with her circulation, and there were problems placing the cannula, so Dr Hale was drawn away to assist with that task. Dr Hale observed that Aishwarya appeared profoundly shocked at that point, from a circulatory point of view, and very unwell.[195]

155. Her blood gas result, taken soon after, showed Aishwarya had severe acidosis, including a lactate of 12, which was at the very severe end of the spectrum and would signify a mortality rate of in excess of 70%. Dr Hollaway also said that looked at in the context of everything else, Aishwarya's likely mortality rate was probably far greater. Dr Hollaway observed that he has treated sepsis on many occasions, and he has never treated anyone as unwell or who has died on him like Aishwarya did.[196]

156. I note at this stage that the independent experts who reviewed Aishwarya's care made no criticism of the resuscitation efforts that were undertaken to try to save Aishwarya and the resuscitation was considered to be of the highest standard. Sadly, however, Aishwarya was at that stage so critically unwell that she could not be saved despite the best efforts of the resuscitation team.

157. Aishwarya was immediately given intravenous fluids, antibiotics (ceftriaxone and tazocin) at 7.45 to 7.50 pm, dextrose for low blood sugar level and the anti-seizure medication midazolam as there was concern for seizure activity. Aishwarya briefly appeared to stabilise a little, then while preparing her for intubation, Aishwarya had a

[190] T 359.
[191] T 327.
[192] T 329.
[193] T 330.
[194] T 333.
[195] T 414 – 417.
[196] T 344, 350, 352, 445.

large vomit. Dr Hollaway noted that sometimes in a patient as critically unwell as Aishwarya, a simple act of a vomit, which will cause a brief drop in blood pressure, can make the person haemodynamically unstable.[197] He thought it was possible this may have occurred in Aishwarya's case, as shortly after she then went into cardiac arrest (her heart stopped beating) at 8.21 pm and cardiopulmonary resuscitation was administered. There was clinical suspicion for a possible adrenal insufficiency, which can be caused by a critical illness such as sepsis, and she received hydrocortisone.[198]

158. The After Hours Clinical Nurse Specialist, Elizabeth Kennedy, had become aware that the ED was busy from discussion with staff from other areas of the hospital. She came to the ED to collect a patient who was being admitted to a ward. CNS Kennedy arrived in the ED during Aishwarya's resuscitation and, as she has specialised skills and experience in assisting with resuscitation, she went to see if she could assist. CNS Kennedy's offer to assist in the resuscitation was declined, so she left to take the patient to the ward. Aishwarya's parents had been asked to leave the room during the resuscitation, as it is a very confronting process. When CNS Kennedy returned to the ED, she offered to sit with Aishwarya's parents. CNS Kennedy sat with Aswath and Prasitha and tried to provide them with support and information as best she could while the resuscitation continued. CNS Kennedy went into the room at one stage and asked Dr Hollaway if someone could come out to speak to the family and explain what was happening, but at that stage all of the staff in the bay were too busy with the resuscitation to leave.[199]

159. However, shortly after they briefly established a return of circulation, so Dr Hollaway did then come out of the resuscitation room and spoke to Aishwarya's parents in the presence of CNS Kennedy. He had left Aishwarya in the care of the intensive care consultant, Dr Jarrod Cross, at the time.[200]

160. Dr Cross had been called to assist due to his expertise in dealing with critically unwell children. Dr Hollaway explained to Aishwarya's parents that they had got her heart rate back, but she was extremely sick and could very well have another cardiac arrest. He then returned to the resuscitation room, where CPR had been restarted as the brief return in circulation hadn't been enough to sustain good blood flow to the body. Dr Cross gave evidence that Aishwarya's period of electrical activity and faint pulse had been brief and not associated with reliable cardiac output.[201]

161. After 43 minutes of CPR, it was concluded that Aishwarya could not be revived. Blood gas results were received that were essentially not consistent with life and as a group it was discussed and ultimately agreed that there was nothing more that could be done. Evidence was given by the doctors involved in making this difficult decision that they explored with all of the members of the resuscitation team whether there were any other options that could appropriately be attempted before they stopped the resuscitation efforts. Every option was considered, but unfortunately there was nothing

[197] T 353.
[198] T 334 - 335; Exhibit 1, Tab 4.
[199] T 455 – 459.
[200] T 460 – 461.
[201] T 336, 353, 445.

more they could do for Aishwarya.[202] Dr Hale said he felt that "[e]verybody threw absolutely everything they had into trying to save Aishwarya"[203] and they were all devastated that they couldn't help her.

162. After the decision to cease resuscitation was made, Aishwarya's parents were brought back into the room. Resuscitation attempts were ceased and Aishwarya was pronounced life extinct at 9.04 pm by Dr Hollaway.

163. Aishwarya's parents were brought into the resuscitation bay by CNS Kennedy at the time the CPR was ended, so they could be there with her. They were understandably devastated and became physically and emotionally overwhelmed. Reading the statements of witnesses, it is clear that it was a harrowing scene and no one who witnessed Aswath and Prasitha experiencing the raw pain of their grief will ever forget.

164. It was acknowledged at the inquest what a difficult decision it was for the medical staff to end the resuscitation. These kinds of sudden deaths without any preceding accident, illness or warning are rare in children's hospitals and devastating for all involved. Dr Hollaway acknowledged Aishwarya's parents great pain and suffering and expressed how he was heartbroken not to have been able to save her. He also sincerely believes that no one at PCH who was involved in Aishwarya's resuscitation will ever forget her. These decisions are never made lightly and all involved truly and sadly believed there was nothing more they could do to save her before her death was confirmed.

165. Aishwarya's cause of death at that time was given as cardiac arrest with a contributing factor of possible sepsis, but it was noted that her precise cause of death was unknown and her death was reportable to the coroner.[204]

166. The WA Police were notified and police officers attended the hospital and spoke to Dr Hollaway, who provided a short briefing in relation to the circumstances of the death. At the time, Dr Hollaway was uncertain of the cause of death but was able to say that bacteria had been found on her full blood count film that were aggressively attacking the white and red blood cells. This was a very unusual finding and the microbiologist believed at that time that the bacteria might be a meningococcal disease but this had not been confirmed at that stage due to the limited time for testing to be performed.[205] Attending police officers also spoke briefly to Aishwarya's parents, but they were only able to provide limited information due to their understandably distressed state. Aishwarya's father performed the necessary identification and Aishwarya's body was then taken to the State Mortuary so that post mortem investigations could commence to try to establish the cause of her death.[206]

167. I note that during the resuscitation an issue of concern was identified that the blood gas machine was cycling and wasn't able to be used. This caused a slight delay, but

[202] T 421.
[203] T 424.
[204] T 336 – 337; Exhibit 1, Tab 2 and Tab 3.
[205] T 333 – 334, 357.
[206] Exhibit 1, Tab 8 and Tab 9.

did not impact on the death. Dr Hollaway confirmed that since this time, there are now at least two such machines available, so that if one is cycling the other is generally still available.[207]

POST MORTEM FINDINGS

168. The initial post mortem examination was conducted on 7 April 2021 by Forensic Pathologist Dr Nina Vagaja. A full body post mortem computerised topography (CT) scan was performed prior to the post mortem examination. The radiology was reviewed by a Consultant Paediatric Radiologist who noted bilateral pleural effusions and underinflated lungs, fluid-filled small bowel loops and thick, contracted urinary bladder. The skeletal structures were normal.[208]

169. Dr Vagaja noted from the physical examination that there was nothing unusual about Aishwarya's physical development and her organs were anatomically normal and well-developed. There were no signs of injury, although there were signs of medical intervention associated with CPR. Some of the significant findings from the physical examination were:[209]

- Watery bowel contents;
- Enlarged mesenteric lymph nodes;
- Epicardial petechiae and focal myocardial bruising;
- Bruising of the thymus;
- A few bruises under the scalp and in the deep neck tissues;
- Congested adrenal gland;
- Enlarged, thickened urinary bladder;
- Congested lungs; and
- Pleural effusions.

170. Dr Vagaja reviewed the results of blood tests on antemortem samples collected at 7.50 pm at the hospital before Aishwarya's death, which showed evidence of renal failure (raised urea and creatinine) and derangement of liver function. Blood-C reactive protein, a marker of systemic inflammatory response, was very high.[210]

171. Dr Vagaja believed at the end of this examination that the death was possibly due to natural causes but the specific cause was undetermined at that stage. Dr Vagaja initiated a large number of further investigations to attempt to determine the exact cause of death.[211]

172. Multiple tissues were examined under the microscope by Dr Vagaja and colleagues from Anatomical Pathology at PCH. There was microscopic evidence of widespread tissue injury and variably expressed inflammatory cell activity, which affected most severely the kidneys, heart muscle and thyroid gland, and which was associated with

[207] T 330.
[208] Exhibit 1, Tab 5.
[209] Exhibit 1, Tab 4 and Tab 5.
[210] Exhibit 1, Tab 5
[211] Exhibit 1, Tab 4.

abundant growth of bacteria in these tissues. Inflammation was also present in the liver and small and large bowel. There was no evidence of pneumonia, although focally there was evidence of lung tissue injury, as may occur in the setting of significant illness. The epiglottis and tonsils showed inflammation consistent with upper respiratory tract infection and examination of the urinary bladder demonstrated chronic inflammatory changes, consistent with chronic bladder inflammation (cystitis). The bruises in soft tissues, which were observed at post mortem examination, were fresh and were considered a sign of abnormal clotting (coagulopathy), which may occur in the setting of sepsis. Examination of tissues which regulate immunity (bone marrow, spleen, thymus, lymph nodes, tonsil tissue and others) did not show features to suggest underlying immunodeficiency. However, Dr Vagaja noted that this does not exclude the possibility that a diminished or abnormal immune response to infection occurred in this case.[212]

173. Biochemistry testing suggested indicated it was not likely Aishwarya was diabetic.[213]

174. An examination of the brain by a neuropathologist showed no significant abnormalities. However, microscopic examination demonstrated changes in the brain in keeping with end-organ injury, in the setting of circulatory failure. The changes were in keeping with a survival time of some hours.[214]

175. Virology testing showed no evidence of underlying bloodborne disease and testing was negative for Covid-19 infection. Rhinovirus RNA was detected in the swabs from the nose and throat but not in the lower airways and lungs. Rhinovirus is a common virus in humans and is the predominant cause of the common cold.[215]

176. Examination of antemortem blood film by a haematologist demonstrated features of fulminant sepsis. However, at the time of that test, the organism responsible for the disease could not be diagnosed. Multiple other microbiology tests were performed post mortem. They excluded *Streptococcus pneumoniae* (pneumococcal disease) and *Neisseria meningitidis* (meningococcus). *Streptococcus pyogenes* (emm-type 4.0), a type of Group A *Streptococcus*, was ultimately identified from DNA studies performed on blood samples. The emm-4 strain is a major cause of invasive *S. pyogenes* disease in Australia. The DNA sequencing analysis established that this microorganism was responsible for the overwhelming infection that caused illness and death in Aishwarya.[216] It could not, however, clarify the likely site of Aishwarya's original infection.[217]

177. Dr Vagaja explained in her report that Group A Streptococcal infections are common and can cause illness such as sore throat (pharyngitis), scarlet fever or impetigo (school sores), and in some instances can cause a severe illness such as rapidly progressive sepsis. Sepsis is an infection of the bloodstream resulting in a cluster of symptoms such as: drop in blood pressure, increase in heart rate and fever. The

[212] Exhibit 1, Tab 5.
[213] Exhibit 1, Tab 5.
[214] Exhibit 1, Tab 5 and Tab 6.
[215] Exhibit 1, Tab 5.
[216] Exhibit 1, Tab 5.
[217] Exhibit 2, Tab 28.

symptoms described in Aishwarya were consistent with a fulminant sepsis, which was likely due to rapid multiplication and spread of bacteria into her bloodstream (bacteremia) and their spillage into organs and tissues, likely associated with the noxious effects of the bacterial toxins ("toxic shock syndrome"). This overwhelmed her immune system and caused circulatory collapse, with critical loss of blood supply to organs and multiorgan failure.[218]

178. Toxicology testing did not add anything of significance to the post mortem findings.[219]

179. Following receipt of the results of all further investigations on 29 August 2021, Dr Vagaja formed the opinion the cause of death was multiorgan failure due to fulminant sepsis (*Streptococcus pyogenes*).[220] Dr Vagaja expressed the opinion the death was consistent with natural causes.[221]

180. Dr Vagaja noted in her report that she kept a sample of blood for genetic testing in case a possibility of underlying immunodeficiency was to be explored. Following discussions with Consultant Immunologists from PCH and Sir Charles Gairdner Hospital (SCGH), the opinion was provided that a primary immunodeficiency was considered unlikely in this case. Therefore, at this stage, genetic testing has not been pursued, although a DNA sample is available if Aishwarya's family wish to proceed with genetic testing at a later date. If a relevant immunological diagnosis was established from such testing, it could be added to the cause of death, but would not replace it.[222]

DR SPEERS' OPINION

181. Dr David Speers is an Infectious Diseases Physician and Infection Control Officer at SCGH, the Head of Department of Microbiology at PathWest and a Clinical Associate Professor at the School of Medicine and Pharmacology at the University of Western Australia. He is a member of the Continuing Professional Development Program of both the Royal Australasian College of Physicians and Royal College of Pathologists of Australasia. Dr Speers has given evidence in previous coronial inquests in Western Australia as the Court's independent expert. Dr Speers' extensive Curriculum Vitae was provided to the Court and made available to counsel. There was no dispute about his expertise to speak on the subject of the microorganism that caused Aishwarya's death.[223]

182. Dr Speers was not involved in Aishwarya's case but was provided with a large amount of materials to assist him in providing an expert opinion, based on his specialised knowledge of infectious diseases as it pertains to the death of Aishwarya. He prepared a report, answering specific questions put by Counsel Assisting, Ms Tyler, in the letter of instruction.[224] Dr Speers also gave evidence at the inquest to expand on his report,

[218] Exhibit 1, Tab 5.
[219] Exhibit 1, Tab 5 and Tab 7.
[220] Exhibit 1, Tab 4 and Tab 5.
[221] Exhibit 1, Tab 5.
[222] Exhibit 1, Tab 5.
[223] Exhibit 2, Tab 28.
[224] Exhibit 2, Tab 28.

including addressing a large amount of additional materials that were provided prior to the inquest.

183. Dr Speers explained that *Streptococcus pyogenes* (also known as Group A Streptococcus or GAS) is a frequent coloniser of the throat in people without causing symptoms. This means many people can be carrying it in the community without having any symptoms or appearing unwell. The carriage rate is highest among schoolchildren than in adults. *Streptococcus pyogenes* is highly contagious, and transmission occurs by respiratory droplets from someone with the infection in their upper airways or from direct contact with someone with skin sores. *S. pyogenes* cases are more likely in larger groups of people physically close together, such as in schools. Once colonised on the skin or upper airways (throat and nose) non-invasive or invasive disease may follow, if the organism finds its way into the body.[225]

184. Dr Speers explained that the organism will usually find its way into the body through the skin barrier or the mucosal barrier of the throat. A preceding viral illness can increase the risk of this occurring through the throat, as it can disrupt the normal protective mechanisms that keep the bacteria away from entering the body.[226]

185. Common non-invasive disease includes "strep throat" (pharyngitis) and skin infections. Strep throat usually occurs within days of being colonised and is most common in those aged 5 to 15 years, with a peak incidence in the first few years of school. This is characterised by a sore throat for two to five days if left untreated, but is usually self-limited. A bright red rash over the body (Scarlet Fever) may develop and the rash may also be petechial (small non-blanching red dots). Children may also present with vomiting, abdominal pain and seizures. The common skin infections include cellulitis and school sores. An uncommon consequence of these non-invasive infections can be rheumatic fever and glomerulonephritis (kidney disease).[227]

186. Much less common, but more serious, are invasive *S. pyogenes* diseases such as bacteraemia (*S. pyogenes* in the blood), streptococcal toxic shock syndrome, pneumonia (lung infection), necrotising fasciitis (infection of the deeper tissues under the skin), myositis and myonecrosis (muscle infection), osteomyelitis (bone infection) and septic arthritis (joint infection).

187. The incidence of invasive *S. pyogenes* disease has been reported to be increasing over the last two decades in a number of countries, including Australia. A source of entry for the *S. pyogenes* is only found in approximately half of invasive cases. Chicken pox is a known risk factor for invasive *S. pyogenes* disease, and there is also an association between invasive *S. pyogenes* and viral respiratory tract infections, as noted above. The strongest association is following influenza infection, with the mechanism thought to be viral damage to the respiratory lining allowing increased *S. pyogenes* adherence and suppression of the local immune response.[228] I note a recent media report indicated that there has been a further dramatic surge in severe cases of Group A

[225] T 476; Exhibit 2, Tab 28.
[226] T 476; Exhibit 2, Tab 28.
[227] Exhibit 2, Tab 28.
[228] Exhibit 2, Tab 28.

Streptococcal disease in Australia in 2022, with the trend looking to be continuing into 2023.[229]

188. Invasive *S. pyogenes* disease can be lift threatening, with half of cases in children requiring paediatric intensive care admission. The mortality in children with invasive *S. pyogenes* disease is from 3.6 to 3.8% but can reach up to 28% or more for streptococcal toxic shock syndrome.[230]

189. Streptococcal toxic shock syndrome is a particularly severe form of septic shock due to *S. pyogenes*. It occurs due to certain pyrogenic (fever causing) toxins that cause a sudden and overwhelming inflammatory response that presents as sudden shock (low blood pressure due to circulatory collapse) and multi-organ failure. The organ systems affected are the kidneys, liver, lungs and blood. There are defined clinical and laboratory criteria for the diagnosis of streptococcal toxic shock syndrome. The clinical criteria include kidney (renal) impairment, coagulopathy (disordered blood clotting), liver involvement, acute respiratory distress syndrome or acute generalised oedema (swelling), a rash and soft tissue necrosis (necrotising fasciitis, muscle infection or gangrene). Once initial symptoms appear, the disease progresses rapidly and, if left untreated, multi-organ failure intervenes. The time from the onset of the initial symptoms of fever, nausea and vomiting and diarrhoea to shock (hypotension) is within 24 to 48 hours. Streptococcal toxic shock syndrome has the highest mortality of all invasive *S. pyogenes* disease. Even in high income countries the case fatality rate can be up to 28% compared to 10-15% for other invasive *S. pyogenes* disease, although I note Dr Speers' evidence that the mortality is generally higher in adults than children.[231]

190. Importantly, while school sores or pharyngitis are relatively easy to diagnose as they have characteristic appearances, such as a bright red rash (like sunburn),[232] the suspicion for invasive *S. pyogenes* disease is hard to diagnose unless there is an obvious source of infection. In more generalised presentations, health practitioners usually need to look at the constellation of more general symptoms, in combination, to try to identify potential cases of invasive *S. pyogenes* and differentiate them from other viruses or infections.

191. Dr Speers had originally considered a suggestion that the first sign of Aishwarya's illness had been a sore throat on 1 April 2021. When he was advised that the first report of her becoming unwell was actually on the Friday morning, being 2 April 2021, Dr Speers observed that this information "would illustrate that the progression was even more rapid"[233] than he had first thought.[234]

192. In his report, Dr Speers noted that Aishwarya's observations taken at 5.50 pm recorded:[235]

---

[229] https://www.abc.net.au/news/2023-01-17/group-a-streptococcal-explainer-cases-in-australia/101854070.
[230] Exhibit 2, Tab 28.
[231] T 477; Exhibit 2, Tab 28.
[232] Exhibit 2, Tab 28.
[233] T 475.
[234] Exhibit 2, Tab 28.
[235] Exhibit 2, Tab 28.

- a raised heart rate (150 beats/min);
- a raised respiratory rate (44 breaths/min);
- a fever (38.8°C);
- normal blood pressure (114/103); and
- good oxygen saturation (98% on room air).

193. Aishwarya was also said to be alert but clingy, grunting in pain, pale but not dehydrated, with a clear chest.[236]

194. After deteriorating in the waiting area over the next hour and a half, at 7.20 pm she was recorded as being weak and unable to raise her hand to take medication, and shortly after she was taken into a treatment room and found to be:[237]

- febrile, with a temperature of 39.5°C,
- her pulse was 151/beats/min;
- her oxygen saturations had fallen to 95% on room air; and
- her blood pressure was very low at 59/42, a dramatic change from before.

195. After antibiotic treatment and prolonged unsuccessful resuscitation attempts, her death was declared just after 9.00 pm.

196. Dr Speers commented that Aishwarya's illness, as described above, whether commencing on the Thursday or Friday, was one of a rapidly progressing disease process. Dr Speers noted that rhinovirus was identified later at post-mortem as was active inflammation of the tonsils, although Aishwarya did not have the usual features of 'Strep throat' such as a persisting very sore throat and enlarged lymph nodes of the neck. Dr Speers theorised that it was possible Aishwarya was colonised with *S. pyogenes* in her airways and the rhinovirus infection allowed entry of the *S. pyogenes* into her body to cause invasive *S. pyogenes* disease. He expressed the opinion the symptoms of headache and feeling warm noted on the morning of 2 April 2021 were very likely caused by the early stages of the *S. pyogenes* infection.[238]

197. Aishwarya's disease progressed over the next day and a half. The fever persisted and new symptoms of vomiting and soreness developed. The pain relief given to Aishwarya by her parents would have helped with her symptoms during the day, but her condition still slowly worsened over the next 24 hours. Dr Speers indicated that the fever, soreness, headache, vomiting then diarrhoea were all consistent with an underlying bacterial infection. Dr Speers commented that the "development of cold hands in the setting of fever, pale skin, lethargy and body soreness are signs of sepsis, as is slurred speech and confusion, vomiting and rapid breathing. The paleness and cold hands is due to diversion of the blood to her vital organs as a compensatory mechanism to maintain the body's essential functions."[239]

---

[236] Exhibit 2, Tab 28.
[237] Exhibit 2, Tab 28.
[238] Exhibit 2, Tab 28.
[239] Exhibit 2, Tab 28, p. 4.

198. Dr Speers expressed the opinion that at the time Aishwarya presented to the PCH ED, she already had a number of compensatory mechanisms in action to help maintain her blood pressure and oxygen level in her blood. Dr Speers explained that she showed evidence of vasoconstriction, which is the pulling back of all the blood from the extremities to allow the blood to continue to perfuse the vital organs, predominantly the brain, resulting in cold peripheries. Aishwarya also had an elevated heart rate, which was due to her heart responding to the sepsis by increasing the rate of beating to maintain the blood pressure to ensure blood supply to the vital organs such as the brain. She also had an increased breathing or respiratory rate due to a metabolic acidosis from her sepsis, as her body tried to compensate for too much acid in the blood produced by organ dysfunction by breathing to exhale the acid as carbon dioxide.[240]

199. Her venous blood gas samples taken during her resuscitation showed severe metabolic acidosis, including a high lactic acid level, which indicated the muscles had been starved of oxygen and food as the blood was diverted away to vital organs. Dr Speers noted that some studies have shown an association of high lactate (greater than 5 mmol/L) with mortality in children with sepsis, and Aishwarya's lactate level during resuscitation was 12 mmol/L.[241]

200. Aishwarya did not have a drop in blood pressure at the early stage when her observations were taken in the waiting area. However, Dr Speers stated that "the drop in blood pressure (septic shock) due to sepsis occurs at a later stage in younger people and children compared to older adults and they are able to maintain this until the late stage of septic shock when they are completely overwhelmed by the infection."[242] Dr Speers believes this was the case for Aishwarya. While her body was able to compensate, and keep her brain perfused, she still did not appear critically unwell despite her worsening state. However, when those compensatory mechanisms all began to fail, she suffered a very rapid deterioration, which is consistent with how these cases progress.[243]

201. Dr Speers observed that after Aishwarya's death, the PCH doctors formulated a presumptive diagnosis of septicaemia based on examination of the peripheral blood film in the laboratory, which showed bacteria present within the blood cells. This was significant, as Dr Speers explained that it is very uncommon to visualise the bacteria in a blood film because the bacterial load is usually below the level of microscopic detection. Visualisation of the bacteria is only seen when the bacterial load is extremely high, as it must have been in Aishwarya's case. Sepsis due to *S. pyogenes* was then confirmed from testing of post mortem samples. Other results from the testing also confirmed severe sepsis.[244]

202. Dr Speers gave evidence at the inquest that there is emerging evidence to suggest that the presence of a very high bacterial load was a prominent risk factor for a poor outcome in Aishwarya's case. He explained that "the burden of bacteria is the

[240] T 490; Exhibit 2, Tab 28.
[241] Exhibit 2, Tab 28.
[242] Exhibit 2, Tab 28, p. 4.
[243] T 490.
[244] T 478 – 479; Exhibit 2, Tab 28.

precipitant or the trigger of the whole inflammatory response, which we call sepsis."[245] It has apparently been shown in a study that burden of bacteria is a stronger predictor than timing of antibiotics for a poor outcome, and it has been shown proportionally that the higher the burden, the more the risk of a poor outcome.[246]

203. Dr Speers expressed the opinion that Aishwarya's presentation was consistent with a rapidly progressive invasive *S. pyogenes* disease and was consistent with a streptococcus toxic shock syndrome process. Her body had managed to compensate for some time, but soon after her presentation to PCH, her compensatory mechanisms to keep blood supply to her vital organs began to fail and she suffered a rapidly deteriorating course resulting in cardiac arrest. Dr Speers noted that, in themselves, none of Aishwarya's signs and symptoms were specific for invasive *S. pyogenes disease*, or for sepsis in general, but it is the constellation of them together that raised the suspicion for sepsis in the absence of any other identifiable cause. However, at the time of her presentation, there seems to have been a focus on her diarrhoea and vomiting, which may have resulted in the initial assessment of Aishwarya's illness to be due to a gastrointestinal cause such as gastroenteritis.[247]

204. By the time the severity of her illness had been recognised, Aishwarya had the signs of sepsis (fever, fast heart rate and breathing rate) and the indications for a poor outcome including rapid disease progression, markers of severe illness (confusion, severe pain and cool extremities) and microscopic detection of bacteria in her blood film. In Dr Speers' opinion, these markers indicate that by the time treatment commenced, "she had reached a stage of septic shock which had become irreversible at the time of the resuscitation attempts."[248]

205. The important question that flows from this is, was the disease similarly irreversible at the time Aishwarya arrived at the PCH Emergency Department, approximately two hours earlier?

Timing of the Diagnosis and Treatment of Sepsis

206. "Sepsis, in simple terms, is an inflammatory response to infection and is characterised by organ dysfunction evidenced by lowered conscious state, low blood pressure, low urine output, rapid breathing and pulse, and cool mottled skin. Septic shock is when the sepsis is associated with profound circulatory and metabolic abnormalities such that the low blood pressure cannot be corrected by adequate intravenous fluid resuscitation. In most patients, the beginning of septicaemia is marked by acute onset of fever, chills and generalised muscle aches or pains in the back and thighs."[249]

207. Dr Speers advised that,[250]

[245] T 478.
[246] T 478.
[247] Exhibit 2, Tab 28.
[248] Exhibit 2, Tab 28, p. 5.
[249] Exhibit 2, Tab 28, p. 5.
[250] Exhibit 2, Tab 28, p. 5.

recognising a patient with sepsis can be challenging as clinical features may be absent or overlooked and the early signs of sepsis are non-specific (can be found in those without sepsis). People with septicaemia without a recognised source of infection present with the most non-specific clinical features and have the highest fatality rate. It is a feature in young, previously well people with sepsis that they are able to support their blood pressure with compensatory mechanisms until these mechanisms are eventually overwhelmed resulting in a very rapid deterioration, literally within minutes in some cases. The critical issue is to recognise that sepsis may be present before this happens because the mortality rate is much higher as the inflammatory process may have become irreversible by this stage.

208. Dr Speers noted in his report that *S. pyogenes sepsis* has the same features as other causes of sepsis but may also have other clinical features if a toxin-producing strain is responsible. The toxin-mediated features in streptococcal toxic shock syndrome include vomiting and diarrhoea, sore muscles, conjunctival injection (redness of the whites of the eyes), confusion and a widespread rash that looks like sunburn.[251] Some of these symptoms were present in Aishwarya's case, but not all.

209. The investigations usually performed when infection is suspected include a full blood picture to assess the white cell count and platelet count. In the setting of a systemic infection the white cell count (neutrophils) is usually raised, and if the process has been underway for a number of hours the platelet count may also be raised. This is called an acute inflammatory response. However, in overwhelming acute sepsis the white cell count and the platelets can be low, indicating bone marrow failure due to the infection. Dr Speers believes this was the case with Aishwarya.[252]

210. A kidney and liver function, a blood sugar level and a C-reactive protein are also recommended. In Aishwarya's case, the first pathology tests performed at the time of resuscitation showed kidney impairment and abnormal liver function. The full blood picture showed bacteria and the C-reactive protein was significantly raised. These findings are all consistent with sepsis. In most instances, as was the case for Aishwarya, the bacterial cause for the sepsis is not initially known.

211. In his evidence at the inquest, Dr Speers observed that Aishwarya's lactate was particularly high in the results taken at 7.30 pm, which he suspected indicated that the septic shock "must have been in progress not just in the last few minutes but probably longer, going back at least several hours."[253] Dr Speers believes that if blood tests had been done around the time Aishwarya arrived at PCH two hours earlier, "it would have shown similar abnormalities, but they may not have been as severe as the ones at 7.30 that night."[254]

212. The role of specific microbiological diagnostic tests like blood cultures and PCR tests are for confirmation and organism identification. The results are not, however,

[251] Exhibit 2, Tab 13.
[252] Exhibit 2, Tab 28.
[253] T 480.
[254254] T 481.

necessary before first line treatment is instituted, as their results are delayed. For example, a blood culture usually takes 12 to 24 hours. Therefore, early administration of empirical antibiotics to cover the major pathogenic bacteria that cause sepsis and toxic shock is recommended when managing acute presentations of suspected sepsis, along with supportive therapies. Microbiological cultures are then performed to identify the particular bacteria, and then the antibiotic therapy can become more tailored.[255] Dr Speers advised that the antibiotics recommended for *S. pyogenes* depend on the disease being treated. Non-invasive disease is generally treated with oral antibiotics. The treatment of invasive *S. pyogenes* disease depends on the site of infection and whether sepsis has developed. When sepsis is involved, management of the sepsis is required (organ support such as intravenous fluids) together with specific antibiotic therapy for *S. pyogenes*.

213. As the specific bacteria wasn't known when the resuscitation commenced for Aishwarya, she was administered ceftriaxone, a broad-spectrum antibiotic to provide coverage of the major pathogenic bacteria that cause sepsis in children. If it had been known that *S. pyogenes* was the cause of her severe sepsis and septic shock, then the recommended antibiotic would have been high dose intravenous penicillin plus clindamycin. Ceftriaxone is an alternative to penicillin, and Dr Speers noted it would be equally effective. Aishwarya was also given the antibiotic tazocin, which would also be effective against *S. pyogenes*. In streptococcal toxic shock syndrome the same antibiotics are recommended with the addition of normal immunoglobulin (human antibodies). However, Dr Speers noted that in Aishwarya's case, he does not believe that the addition of clindamycin and intravenous immunoglobulin, which are the only things missing from the recommended therapy, would have saved her life. This is because Dr Speers believes by the time the antibiotic therapy was commenced, Aishwarya's deterioration to multi-organ dysfunction was too advanced for these medicines to have influenced the outcome.[256]

214. Dr Speers expressed the opinion that the resuscitation attempts and investigations performed were appropriate and reasonable, but it was too late to prevent Aishwarya dying shortly after her sepsis was recognised.[257]

215. Returning to the question I posed earlier, would this position have changed if Aishwarya had received the same treatment two hours or so earlier and further, were there signs that should have led to that treatment at that earlier stage?

216. Dr Speers noted that the recognition of sepsis in children presented to Emergency Departments can be challenging, due to the common childhood infections presenting with fever, the poor predictive value of the early features of sepsis, and the capacity of children to compensate until the late stage of developing septic shock.[258]

217. In this case, Aishwarya was given a triage code of 4, consistent with a presentation of diarrhoea and vomiting without dehydration. This would have changed to a triage code of 3 if there was suspected sepsis in a physiologically stable patient, which would have

[255] Exhibit 2, Tab 28.
[256] Exhibit 2, Tab 28.
[257] Exhibit 2, Tab 28, p. 10.
[258] Exhibit 2, Tab 28.

changed the recommended time to be assessed and treated from 60 minutes to 30 minutes. However, Dr Speers acknowledged at the inquest that the physical barriers to triage that were in place at PCH would have made it difficult for the triage nurse to identify sepsis at that stage.[259]

218. In relation to the brief assessment by Dr Teo, Dr Speers commented that the white patches on their own did not fit easily with a diagnosis of sepsis. While bacterial sepsis can lead to infection of the eye, it is usually associated with a red, painful eye rather than what Dr Teo observed. Dr Speers did suggest that the white patches Dr Teo observed could possibly have been white pus, but it was not seen at post mortem and Dr Speers said he was a little uncertain as to what, in the end, the white patches actually were. Dr Speers noted that Dr Teo appeared to only be focussing on the white patches in the eye, and because his inspection was limited and not holistic, he did not observe the other features that would have been apparent at the time (such as rapid pulse rate, rapid breathing, fever and cold hands) that might have assisted him to recognise that Aishwarya was seriously developing sepsis.[260]

219. Dr Speers referred to the set of observations performed at 5.50 pm by Nurse Vining, which found a fast heart rate, a fast breathing rate and a fever but normal systolic blood pressure and oxygen level. In the assessment of a febrile (feverish) child, discussion with a doctor is recommended if it is felt the child is unwell. Dr Speers commented that Aishwarya had features suggestive of an unwell child, including pallor, fever, fast heart rate and breathing rate. She also had widespread soreness and pain, with a notation on the triage assessment that she was grunting in pain. Dr Speers suggested that after the observations, and including her obvious pain, an assessment of physiologically stable suspected sepsis would have been warranted.[261] However, Dr Speers stated that he expects "Aishwarya's signs of more severe illness (pallor, fast heart rate, fast breathing rate, cool extremities and widespread pain) were not recognised at the time"[262] as they do not seem to have prompted orders to repeat her observations more frequently. Dr Speers understood that the nurse taking the observations was a less experienced nurse, which he took to be the explanation why the observations taken at that time did not trigger her to follow the sepsis pathway, or at least seek a senior nurse or medical review.[263]

220. Dr Speers also noted that one of the other red flag signals to suspect sepsis, along with fever, fast heart rate and fast breathing rate, is parental concern to prompt a reassessment for a change in status of the patient. We know that Aishwarya's mother approached the nursing station multiple times, both before the observations were taken and after, but at least an hour elapsed before she was reassessed and her care escalated. Dr Speers commented in his evidence that although all parents are concerned when their child comes to an emergency department, in his view the repeated requests by Aishwarya's parents for help would constitute significant parental concern. Dr Speers noted that Aishwarya's condition rapidly deteriorated after the initial assessment when the observations were taken, and if she was reassessed earlier he would expect that

[259] T 483, 487.
[260] T 483 - 484.
[261] Exhibit 2, Tab 28.
[262] Exhibit 2, Tab 28, p. 9.
[263] T 485, 487.

Aishwarya's observations and appearance would have reflected this and resulted in an earlier admission.[264]

221. Dr Speers acknowledged that systemic inflammatory response syndrome vital signs are common among children presented to an Emergency Department, yet critical illness is rare. The difficulty is therefore in recognising the child more likely to require critical care from the many with potential sepsis indicators. To that end, emergency departments have sepsis pathways for triaging of unwell patients where infection may be responsible to help recognise such cases. This is necessary because classic signs of septic shock like low blood pressure occur late in children as compared to adults.[265] It was unclear to Dr Speers, at the time of preparing his report, whether Aishwarya would have met the PCH Sepsis Recognition and Management guideline applicable at the relevant time, as he did not know what guideline was applicable at that time. Certainly, based on the guideline in place in September 2021, Aishwarya met at least three or more of the clinical criteria to meet the septic shock triage criteria when her observations were taken, and would have met the criteria for consideration of sepsis to instigate medical consultant review, investigations, administration of antibiotics and fluid resuscitation in a resuscitation room within 15 minutes of initial assessment.[266]

222. At the time of giving his evidence in August 2022, Dr Speers had been provided with more information and he believed the sepsis pathway should have been considered based on the observations taken before 6.00 pm and the PARROT chart, although we know Nurse Vining did not complete the PARROT chart for some time.[267]

223. Dr Speers concluded that there was "a potentially avoidable delay in recognition of her severe sepsis."[268] This delay in recognition of these signs may have been contributed to by how common these triggers for sepsis recognition are in presentations to PCH, and the attribution of her symptoms as being due to gastrointestinal illness, as well as the lack of experience of the nurse taking the observations.[269] Dr Speers felt there was a lack of recognition of the seriousness of the underlying disease, which would likely have been apparent if a senior clinical assessment was conducted.[270] Dr Speers also expressed the opinion that "if there were systems in place that would have led to more frequent assessment of physical observations, I think the recognition would have been earlier than the 7.30 at night and the resuscitation attempts would therefore have started earlier."[271]

224. Leading on from this, Dr Speers considered what that potential delay meant for the prospects of Aishwarya's chances of survival. He advised that streptococcal bacteria die within several hours of antibiotic administration and it is, therefore, accepted that the earlier the provision of appropriate antimicrobial therapy in sepsis the better the chance of survival, and this is particularly so the more severe the infective illness. Sepsis guidelines recommend intravenous antibiotic administration within one hour of

---

[264] Exhibit 2, Tab 28.
[265] Exhibit 2, Tab 28.
[266] Exhibit 2, Tab 28.
[267] T 487.
[268] Exhibit 2, Tab 28, p. 10.
[269] Exhibit 2, Tab 28.
[270] T 487 – 488, 493.
[271] T 488.

presentation in septic shock, with delay beyond that time increasing the risk of death.[272]

225. Dr Speers noted that invasive *S. pyogenes* disease is a complex disease process involving many factors other than whether the bacteria are alive or dead, so although it is generally accepted that the early administration of antibiotics is likely to improve outcome overall, other factors such as the bacterial load, the severity of illness at presentation and the rapidity of progression can be more important in predicting mortality. A major factor associated with severity of sepsis is the load of bacteria in the blood, with a high bacterial load in sepsis shown to be an independent strong risk factor for mortality. Dr Speers observed that Aishwarya had a high bacterial load in her blood when tested at 7.30 pm, so it is very likely she had a high bacterial load at the time of her presentation several hours earlier. Sepsis can rapidly progress over hours even when antibiotics are given early. This is an unfortunate reflection of the disease process, which can be irreversible despite the killing of the bacteria.[273]

226. In Dr Speers' opinion, as expressed in his report,[274]

> *Aishwarya is a tragic case of delayed recognition of severe sepsis where, due to her rapid deterioration and significant burden of toxin producing bacteria, there was only a small window for medical intervention to improve her chances of survival. Aishwarya's chances of survival would have increased if she had received antibiotics and supportive care immediately upon presentation to PCH while her compensatory mechanisms for her sepsis were maintaining physiological stability. This is because the benefit of antibiotics along with sepsis supportive care as part of sepsis management is more likely when provided earlier in the child's infection. However, Aishwarya may have continued to decline due to her rapid disease progression, her very high bacterial load on presentation to PCH and her STSS (Streptococcal toxic shock syndrome). This is because her severe STSS disease process may already have progressed at the time of presentation to an irreversible disease process, such that medical intervention several hours earlier could not have prevented further deterioration. This is why the majority of childhood sepsis deaths in previously well children occur less than 24 hours after hospital admission.*

227. Dr Speers was asked to expand upon this opinion in his oral evidence at the inquest. He noted that in looking at the mortality rates for children with sepsis and the timing of provision of antibiotics and intravenous fluid resuscitation, it is important to look at "the cohort of children presenting as being on a spectrum from the most mild sepsis to the most severe septic shock, and then …streptococcal shock syndrome on top of that."[275] At the milder end of the spectrum, the urgency of care is less important. It is for the group in the middle where it makes the most difference, heading towards the severe end of the spectrum. Unfortunately, at the end of the spectrum of severity, for children with extremely high bacterial loads and those with streptococcal toxic shock

[272] Exhibit 2, Tab 28.
[273] Exhibit 2, Tab 28, p. 11.
[274] Exhibit 2, Tab 28, p. 11.
[275] T 488.

syndrome, Dr Speers indicated there will be children where "even with prompt recognition the outcome is still going to be fatal"[276] as it's already too late.

228. Dr Speers noted that Aishwarya had those two factors that would "have both made it less likely for Aishwarya to survive, even with a bit earlier intervention with the resuscitation."[277] In Dr Speers' opinion, Aishwarya's case showed an extremely rare severe disease process of a number of negative prognostic factors or signs that lead to a tragic outcome in previously well children, within the space of one or two days. Dr Speers was unable to say that Aishwarya would definitely have survived if things were done earlier, given the sheer rapidity of her disease progression, the fact she was already in cold shock or compensated shock at the time of presentation to hospital and her rapid demise soon after. Dr Speers gave evidence that only a minority of children would have survived in those circumstances.[278]

229. The problem, Dr Speers explained, is that even though antibiotics will kill of the bacteria after a period of time, it may be that the inflammatory response of the body to the antigens (or proteins on the surface) of the bacteria has already reached the point where it is intractable. The inflammatory response is what we know as sepsis, and it will continue down this cascade of damaging the body because it doesn't require the bacterial antigens anymore. It has reached a point where it has become irreversible septic shock. That is what Dr Speers believes happened in Aishwarya's case, and the process was already irreversible when resuscitation commenced at 7.30 pm and may very well have been already irreversible at 5.30 pm.[279]

230. Dr Speers acknowledged in questioning from counsel appearing for the family that one of the problems is that there is an absence of empirical data to track exactly what was happening with Aishwarya at 5.30 pm.[280] Based on the marked abnormalities revealed in the blood gas tests taken at 7.30 pm, Dr Speers believes there would have been abnormalities if a blood gas was done earlier, because the rate at which her pH changes and lactate accumulated would have been over hours, not minutes, to reach those levels. However, there is no way to say with any certainty what levels they would have reached at that stage.[281]

231. Therefore, while Dr Speers did say that Aishwarya's chance of survival if treatment had been given at 5.30 pm would only have been in the minority, he also gave evidence that there "would have been an increased chance"[282] that she might have survived. That is because the earlier the provision of antimicrobial therapy in sepsis, the better the chance of survival.[283] Dr Speers was unable to suggest a percentage survival figure. He could only indicate that there would be a small chance of survival.[284] Sadly, by the time her sepsis was recognised and treated at 7.30 pm, that chance of saving Aishwarya, however small, had passed.

---

[276] T 488, 490.
[277] T 488.
[278] T 488 – 489, 512 - 513.
[279] T 491, 514 - 515.
[280] T 499 – 502.
[281] T 503 – 504, 511 – 512.
[282] T 492.
[283] T 505.
[284] T 506 – 507.

DR NAIR'S OPINION

232. Dr Sathiaseelan Parmersivan Nair is a Specialist Consultant Paediatrician who currently holds the position of Senior Consultant Paediatrician at the Hedland Health Campus in WA and has previously held the positions of Head of Paediatrics at Swan District Hospital and St John of God Hospital in Midland and ED Fellow at the Children's Hospital in Adelaide, amongst other things. Dr Nair has given evidence as an Independent expert witness for the Coroners Court in several paediatric cases in the past.

233. Dr Nair was requested by Counsel Assisting, Ms Tyler, to prepare an opinion regarding whether or not the medical management provided to Aishwarya by health practitioners at PCH on 3 April 2021 was appropriate in all of the circumstances, with a number of specific questions posed for Dr Nair's consideration. Dr Nair reviewed the medical records and other relevant materials obtained during the coronial investigation in order to provide his opinion to the Court. Dr Nair provided a comprehensive written report in April 2022, and he also gave oral evidence at the inquest, in which he expanded upon the information in his written report with the benefit of a considerable amount of additional evidence that was available to him by that time.[285]

234. Dr Nair noted from reviewing her history that Aishwarya had an unremarkable birth and was a healthy child who had been fully immunised and had been developing normally. She did have the usual array of common infections children often get in their first 3-4 years of life and she recovered well from them. There do not appear to be any predisposing underlying medical conditions to make Aishwarya more susceptible to any infections. It is also clear from the evidence that Aishwarya's parents were experienced parents who provided a supportive, loving and caring environment for all their children and were proactive about taking Aishwarya to see their local medical centre when she was unwell.[286]

235. Dr Nair summarised the onset of Aishwarya's illness at home and then considered Aishwarya's presentation to PCH first from the perspective of her parents, then from a review of the medical records and finally from an objective review of the CCTV footage.

236. After reviewing the initial unsigned statements of Aishwarya's parents and the later signed statements, Dr Nair noted that it was evident that Aishwarya's parents were extremely concerned about her deteriorating clinical condition in the ED and despite their multiple efforts to bring this to the attention of staff at PCH, there was no early escalation for review by a senior medical person. Aishwarya's parents also did not appear to have available to them any clear pathway or process whereby they could request a senior review, given their ongoing concerns, or if there was such a process, they were unaware of it. Dr Nair commented that Emergency Departments can be extremely high-pressure and busy environments for healthcare staff and hospital

[285] T 520 – 521.
[286] Exhibit 2, Tab 27.

processes and policies can on occasions be difficult for patients and their loved ones to comprehend, particularly when under stress. Therefore, it is imperative that parents have explained to them, in a supportive and culturally appropriate manner, the process that are involved when they attend an Emergency Department, and particularly when their loved one has suddenly passed away. Dr Nair emphasised that parents should feel comfortable and at ease so that they can express their concerns and feel reassured that healthcare professionals are listening to them.[287]

237. Dr Nair reviewed the CCTV footage, which is extremely difficult to watch. There is no audio, which means its interpretation is left to the viewer to some extent. At the time Dr Nair viewed the CCTV footage, the health staff involved had not provided statements or reports, so the ability to identify people and understand their role was also limited as well as what conversations were occurring. However, this was clarified by statements provided later and their evidence at the inquest, most of which was available to Dr Nair by the time of the inquest.[288]

238. In Aishwarya's case, Dr Nair noted the triage assessment recorded the problem as diarrhoea and vomiting and she had been unwell since the previous day and was now feeling weak and her mother was concerned about her cool hands. Dr Nair noted the initial history obtained appeared incomplete, based on the parents' statements, especially in relation to the duration of the illness, the presence of fever, the evolution of the diarrhoea and vomiting and any other significant complaints. The primary assessment and recommended clinical intervention were left completely blank and no vital signs were taken. It was clarified by Nurse Taylor that taking observations was not part of the usual triage practice at PCH and it would have been difficult to do so given the physical layout of the triage area. Dr Nair acknowledged Nurse Taylor's evidence about the logistics of the space, which he accepted would have made her initial assessment of Aishwarya difficult to perform and it would be easy to miss nuances when conducting a rapid triage assessment.[289]

239. Dr Nair acknowledged that presentations of children with diarrhoea and vomiting are common and in the vast majority of these children the cause is usually of viral aetiology and often a simple trial of fluids is all that is undertaken in the ED. Therefore, there would have been some inherent cognitive bias in terms of the cause of this presentation. However, Dr Nair also noted that the lack of a comprehensive triage and a limited primary assessment of Aishwarya resulted in a Triage score of 4, which certainly contributed to a delay in medical intervention. Dr Nair expressed the view that Aishwarya should have been allocated a Triage score of 3 and, therefore, would ideally have received medical assessment and treatment within half an hour. Dr Nair believes the incomplete triage assessment would have also contributed to a failure to recognise Aishwarya's clinical condition.[290]

240. Dr Nair suggested that asking Aishwarya and her parents for a bit more information about how her illness started might have helped to obtain some more information that could have been a red flag that Aishwarya was not suffering from a typical bout of

[287] Exhibit 2, Tab 27.
[288] Exhibit 1, Tab 27.
[289] T 522.
[290] Exhibit 2, Tab 27.

gastrointestinal illness and the case might have gone on a different trajectory. As Dr Nair commented, the "devil is in the detail"[291] in paediatrics, which takes time speaking with the patient and their caregivers to elicit. However, overall Dr Nair made it clear he was not critical of Nurse Taylor's decision-making, and instead focussed on the pressures placed on her due to the limited staffing and layout of the triage area.[292]

241. In relation to Dr Teo's brief assessment, Dr Nair gave evidence that as a senior clinician, he sympathised with Dr Teo as he recognised that all doctors will, at some stage in their careers, do something similar to what Dr Teo did in this case. Dr Nair reflected that it is part of the learning process for junior doctors, and with the benefit of experience and the powers of hindsight, more senior doctors have learnt to be cautious about focussing on only one concern for reasons of efficiency, rather than taking the time to do a holistic assessment.[293]

242. In terms of what was happening with Aishwarya's eyes at the time Dr Teo saw her, like Dr Speers, Dr Nair found it difficult to provide any explanation for the white spots visible in her eyes, although he felt it was potentially part of the actual disease process, such as conjunctivitis due to the STSS. However, Dr Nair also acknowledged that it was an unusual feature and not an obvious sign or symptom. Nevertheless, Dr Nair commented that while it might not have been obviously related to an infection, "as a clinician it worries me"[294] if there is no explanation for a symptom, and for that reason it would be "dangerous to ignore … and to pass it off."[295] Dr Nair gave evidence his expectation would be that some thought would instead be given to what it might represent. However, Dr Nair also acknowledged that something in the range of up to 95% of children's attendances at emergency departments Australia-wide are related to viral infections, and it is notoriously difficult to distinguish between viral and bacterial infections, so it requires looking for the subtleties, which is difficult when there are time pressures. Dr Nair agreed that those time pressures affected Dr Teo's decision-making that day, but he suggested that in hindsight it could still have prompted him to seek a senior review given he did not know the origin of the spots and the parents were concerned.[296]

243. Regarding the nursing assessment performed by Nurse Vining at 5.50 pm, Dr Nair had originally noted that the vital signs were recorded on the PARROT chart, which led to a score of 2 (due to the respiratory rate and heart rate). According to the chart, this score should have prompted a senior nursing review and increased observations, as well as consideration of a medical review. In addition, Aishwarya's temperature recorded of 38.8°C was above the 38.5°C threshold that the chart suggested should prompt consideration of the local sepsis process.[297] In addition, some sections were not filled in at all, and there were other scores given that did not appear to reflect what was actually being observed.

---

[291] T 524.
[292] T 522 – 526.
[293] T 527 – 528.
[294] T 529.
[295] T 529.
[296] T 530 - 532.
[297] Exhibit 1, Tab 21; Exhibit 2, Tab 27.

244. At the time of the inquest, Dr Nair had been informed that Nurse Vining had not completed the chart at the time of doing the observations, but significantly later. Nevertheless, Dr Nair still considered there were "some extremely concerning features"[298] of Nurse Vining's nursing assessment. He observed that "on a very simplistic level, we've got a child with a very high heartrate 150. We've got a temperature of 38.8,"[299] and based upon usual ranges, that heartrate was inappropriately high in relation to her temperature. She had also been given Panadol two hours earlier, which taken altogether suggested to Dr Nair that there needed to be more discussion with the parents to establish their concerns and the history. Instead, the history appeared to be, once again, limited and seemed to be a repetition of what was previously recorded in the Triage section without any apparent further attempts to verify the history in greater detail.[300]

245. In addition, focussing on the later filled in PARROT chart, Dr Nair commented that:[301]

- Whilst it was noted that there was marked parental anxiety and concern, Nurse Vining recorded the family concern as '0'. It should arguably have been a '1', given she recorded in the associated clinical notes that Aishwarya's mother was "anxious ++"[302] and on the nursing assessment that Aishwarya's father was "worried as pt is cold peripherally & has discoloured iris's."[303] If this had been correctly completed, there would have been a score of 1 allocated for this category;

- The respiratory rate was noted as 44 and given a score of 1, which is correct, however it is in the coloured zone of the PARROT chart, which recommends that if an observation falls within the coloured zone to refer to the Escalation Pathway unless a modification has been made. There does not appear to be any escalation and Aishwarya had only a single set of observations the entire time from 5.33 pm until 7.00 pm (about an hour and a half);

- Similarly, Aishwarya's heart rate was 150 beats per minute, which should have triggered an escalation but did not. Dr Nair commented that it is important to note that given the temperature of 38.8°C, one would expect the heart rate to increase by 10-15 beats for every degree about the normal temperature of 37.6°C. Adjusting for the temperature, Aishwarya's heart rate was still inappropriately high and would represent an unexplained tachycardia out of proportion for her fever. Dr Nair believes this subtle, unexplained tachycardia was probably the single most sign of something else going on, such as sepsis or dehydration. When combined with the cold peripheries and the temperature of 38.8°C, the concern for sepsis increases greatly. Although her blood pressure was still in the normal range initially, Dr

[298] Exhibit 2, Tab 27, p, 18.
[299] T 532.
[300] T 533; Exhibit 2, Tab 27.
[301] Exhibit 2, Tab 27.
[302] Exhibit 1, Tab 21.
[303] Exhibit 1, Tab 21.

Nair noted that it is well known that in unwell children with sepsis the blood pressure falling is a late sign, so it would not have been reassuring. Nevertheless, there does not appear to have been any consideration by Nurse Vining of putting Aishwarya on a possible sepsis pathway;

- As noted above, the temperature of 38.8°C, in and of itself, should have triggered consideration of the sepsis pathway, but it did not;

- Aishwarya's pain was recorded as the lowest category of 0-3, and therefore a score of 0 was allocated on the PARROT chart, despite the clinical comments clearly noting that Aishwarya was "grunting in pain,"[304] which Dr Nair noted was "usually an indicator of severe pain in a child."[305] Dr Nair considered the score should have been above 3 on the pain scale, and thereby receiving a score of at least 1 on the PARROT chart. Dr Nair also referred to the fact that it was noted Aishwarya had been given Panadol by her parents at 5.30 pm, which should have raised concerns as to why there was no relief of the pain, and she was also not offered any further analgesia for her pain for an hour and a half;

- Given all of the above, Dr Nair believes the Total Early Warning Score should have been calculated to be a 4, which the PARROT chart states should prompt a timely medical review in 30 minutes and reassessment of observations within 30 minutes of review.

246. Dr Nair commented that there appeared to have been "a number of missed opportunities to trigger an escalation quite early in the presentation of [Aishwarya] and consideration of sepsis and thereby its prompt management."[306] In particular, the inability to identify an abnormal temperature against a clearly defined prompt on the PARROT chart was of concern.

247. Dr Nair noted that the PCH Sepsis recognition and management pathway identifies that sepsis is a major cause of morbidity and mortality in the paediatric population and can be very challenging to diagnose and manage. The pathway also recognises that every hour a child remains in septic shock the mortality risk doubles, and that care delivered in the first hour after sepsis identification is crucial in ensuring the optimum outcome for the patient.[307] A review of that chart reveals that there were features present in Aishwarya's case that should have triggered sepsis recognition, but unfortunately did not. Dr Nair acknowledged that there were staff resourcing issues and nursing staff were pulled away to other urgent tasks, but he commented that "it's all well and good first to look at it from what everyone else is doing, but if you also look at it from Aishwarya's point of view, for her the clock is ticking."[308]

[304] Exhibit 1, Tab 21.
[305] Exhibit 2, Tab 27, p. 19.
[306] Exhibit 2, Tab 27, p. 19.
[307] Exhibit 2, Tab 27.
[308] T 539.

248. Dr Nair summarised the position as being that Aishwarya had a temperature of 38.8°C, cool peripheries, tachycardia disproportionate to the fever and marked parental concerns on her initial assessment at 5.50 pm, and later a Sepsis Recognition Prompt on the PARROT chart, all of which should have together triggered the sepsis recognition and management pathway.[309]

249. Nurse Vining agreed with many of Dr Nair's other comments and said that in a perfect world, she "would have loved to have been able to spend more time or have the ability to have a room to assess a patient …, but it just wasn't available at that time"[310] and all of the nurses were short staffed, very busy and doing the best they could in the situation.[311] She also had received very little training in relation to the PARROT chart at that time.[312]

250. Dr Nair expressed the opinion that "it is imperative that healthcare staff be provided with the appropriate education and training in the use of the early warning charts such as the PARROT chart, as its use in supporting and assisting clinical decision making in potentially unwell children with evolving sepsis cannot be understated."[313] Dr Nair explained that the early warning charts are designed to reduce medical bias, reduce human error and also prompt requests for early senior medical input and review, so as to recognise sepsis early and manage it appropriately. Dr Nair also emphasised the need for high quality clinical supervision of all staff, both medical and nursing, which I have formed the impression was clearly lacking on this day due to staffing issues.

251. Dr Nair observed that it is evident that Aishwarya's parents were extremely concerned about her deteriorating condition in the ED and they made multiple efforts to bring this to the attention of PCH staff, but there was no early escalation for review by a senior medical person. There also did not appear to be a clear pathway or process where her parents could request that review themselves. Dr Nair noted that since Aishwarya's death, the Department of Health WA has rolled out Aishwarya's CARE Call system (the Call and Respond Early Call System). This ensures a formalised escalation process for families and caregivers who have concerns and provides a clear pathway for seeking more senior assistance. Dr Nair commented that it is reassuring to note that these pathways are now clearly posted in all ED's in Western Australia.[314]

252. Dr Nair noted that the two primary concerns raised by Aishwarya's parents were her irises/eyes looking cloudy, which is an unusual complaint, and her cold peripheries. Dr Nair queried the reasons why these two concerns were not apparently understood and acted upon by the PCH staff, and suggested there may have been communication issues, including due to linguistic differences. Dr Nair expressed the opinion that the cold peripheries, in particular, "should have prompted further opportunities for repeated clinical assessment of her clinical status"[315] as the likelihood that this "directly was related to what was causing her to be unwell was extremely high."[316] It

[309] Exhibit 2, Tab 27, p. 23.
[310] T 261.
[311] T 262.
[312] T 283.
[313] Exhibit 2, Tab 27, p. 19.
[314] Exhibit 2, Tab 27.
[315] Exhibit 2, Tab 27, p. 20.
[316] Exhibit 2, Tab 27, p. 20.

is clear the parental concerns were, in and of themselves, a red flag that something was seriously wrong. Dr Nair suggested that it was possible that given Aishwarya's parents were from a culturally and linguistically diverse background this may have had some contribution to healthcare staff being fully capable of appreciating and understanding the marked concerns her parents had for her condition. It does, however, seem from the evidence that at least the ward clerks, who were having a lot of the interaction with Aishwarya's parents, understood that they were very worried and seeking help.

253. In relation to Nurse Wills' interactions with Aishwarya, Dr Nair expressed the opinion that if there had been a dedicated resuscitation team, it might have been an opportunity to immediately take her into a resuscitation bay given her floppiness as it is a very concerning sign in a child of seven years. However, it was unlikely to have made any difference to the outcome. Once she was taken into Pod B, Dr Nair acknowledged that Aishwarya was quickly assessed and the seriousness of her condition was properly identified and escalated. Dr Nair said he was impressed with this later assessment by Nurse Davies and said her thought her assessment was "spot on."[317]

254. Dr Nair also gave consideration to the resuscitation of Aishwarya in the ED before she died. Dr Nair commented that it is evident that Aishwarya was rapidly deteriorating during this period and she was progressing into intractable shock and multi-organ dysfunction and was in extremis. Like Dr Speers, Dr Nair considers the management during the resuscitation to be appropriate and of the highest standard. Dr Nair noted there was also early involvement of the Paediatric Critical Care Team and they were actively involved in the resuscitation. Dr Nair expressed the opinion the decision to stop the resuscitation was reasonable and appropriate, given that there had been no response to extensive CPR and multiple doses of adrenaline and fluid boluses, and all reversible causes had been actively excluded. Dr Nair believes the resuscitation team at PCH did everything possible to try and save Aishwarya, but unfortunately her clinical condition had rapidly deteriorated to a point where her chances of survival were extremely unlikely.[318]

255. Dr Nair reviewed Dr Vagaja's post-mortem report and indicated he concurred with the post-mortem findings and the cause of death opined by Dr Vagaja.[319]

256. In his final comments and conclusions, Dr Nair observed that very similar cases have occurred in other States in Australia in the past:

- In Queensland, the death of 3-year-old Ryan Saunders in October 2011 from toxic shock syndrome due to undiagnosed Group A Streptococcus (*S. pyogenes*) infection led to the introduction of *Ryan's Rule*, which is very similar to what is now known in Western Australia as *Aishwarya's CARE Call*.

- In December 2018, an inquest was held in NSW into the death of 17-month-old Troy Almond, who had presented to a hospital ED with a fever of 38.9°C, tachycardia, lethargy and vomiting, and had been

[317] T 540.
[318] Exhibit 1, Tab 27, p. 26.
[319] Exhibit 2, Tab 27, p. 29.

discharged with a diagnosis of presumed viral infection. On that medical advice, his parents took him home, where he deteriorated to the point that he could not be saved. The post mortem showed Troy's death was due to overwhelming Group A Streptococcal infection. A key consideration in the inquest was the need for clinicians to consider 'high level parental concern' when considering a child's risk factors for sepsis.

- In Victoria, the death of Lachlan Black, a 2 year 7-month-old little boy who died from Group A Streptococcal infection in August 2014 after being taken to hospital three times and deteriorating after several hours in hospital, led to Monash Health introducing a new program in the ED to allow a patient's care to be escalated by worried family members and a State-wide Paediatric Sepsis Pathway that emphasises the importance of clinicians listening to a family member and having the facility for family members to escalate care to a senior clinician where they remain concerned.

257. Dr Nair spoke of the need, with knowledge of these kinds of cases and Aishwarya's death, for parents to be empowered and made to feel comfortable approaching staff with their concerns, particularly nursing staff. Aishwarya's CARE Call is an important tool in that regard, but Dr Nair also emphasised that it is important to create a culture or environment that is supportive for parents and lets them know they will be listened to if they have ongoing concerns. Dr Nair noted that a review in Queensland had found that of all the SAC1 events in hospital, 70% were related to sepsis and in those cases there was a lack of recognition, escalation and acknowledgment of parental concern. However, Dr Nair has worked in Queensland and seen firsthand that Ryan's Rule is embedded within the culture of the paediatric health system there and works very well to try to avoid those problems.[320]

258. Ultimately, Dr Nair expressed the view that Aishwarya developed Streptococcal Toxic Shock Syndrome and during the period she presented to the ED at PCH, she was progressing into the phase of multi-organ dysfunction, during which time there was a rapid and relentless progressive deterioration until her demise. "Whilst there were some truly missed opportunities to intervene earlier in the Emergency Department," Dr Nair believes that given the nature of the pathological processes and the rapid fulminant nature of the infection that had been evolving in Aishwarya, it is extremely difficult to predict with absolute certainty whether the outcome would have been different if investigations and treatment had been commenced earlier in the Emergency Department. On the balance of probabilities, Dr Nair considers it is unlikely that the outcome would have been any different, although he could not say "with absolute 100 per cent certainty" that she wouldn't have survived if she had received appropriate treatment in the first hour.[321] In the event that Aishwarya did manage to survive this infection, he also felt it was highly likely that her short and longer-term morbidity would have been quite considerable.[322] Dr Nair's opinion is generally consistent with the opinion expressed by Dr Speers in this regard.

---

[320] T 537 - 538.
[321] T 555 - 556.
[322] T 556; Exhibit 2, Tab 27, p. 34.

259. Dr Nair made specific comment about the pH level, which Dr Speers suggested likely took hours to reach the level that was recorded at 7.30 pm in the blood gas results. Dr Nair agreed that the level recorded at that time was severe, to the extent that it was "sitting on the boundaries of almost not being compatible with life."[323] Dr Nair felt the level would have been less when she first presented to the triage nurse, but he agreed it would already have been compromised at that stage as he agreed with Dr Speers that it "would have developed over a period of a few hours."[324]

260. However, whilst it may be the case that earlier treatment may not in the end have saved Aishwarya's life, it was the only chance she had and it was missed. Dr Nair acknowledged that "all of us would always want to feel and know that everything possible had been done when our loved ones become critically unwell"[325] and Aishwarya's parents do not have that reassurance. Rather, they know that they could see that their beloved daughter was critically unwell, but they could not get anyone to listen to them, despite their repeated requests to a number of PCH staff.

261. Dr Nair has expressed the hope that Aishwarya's CARE call, which has now been introduced by WA Health, will benefit all children in Western Australia in the future and hopefully at least give parents a clear pathway to seek help when their requests are being ignored by those in front of them. Dr Nair acknowledged that doctors and nurses are not exempt from human error and cognitive biases, particularly when operating in the high-pressure environment of a hospital ED. Thus, there is a need for procedure and policies to counteract human error and biases as far as possible.[326]

262. Dr Nair acknowledged that paediatric health staff, particularly nurses, are always willing to try their best to provide a high level of care, even in difficult circumstances. He believes there was a lot of anxiety and worry during the early stages of the COVID epidemic, as well as resourcing pressures, and there came a point when many people were exhausted. Dr Nair suggested that management need to protect staff from getting to that point, but he acknowledged this is difficult when recruitment strategies aren't working. He emphasised the need for good communication in those circumstances, to ensure that the staff on the floor feel heard. Dr Nair suggested this requires a change in culture where people at the 'coal face' are kept informed and feel supported, even if there are no easy solutions. Dr Nair also suggested that there needs to be a change in culture to ensure that staff feel comfortable escalating concerns and needs up the chain, rather than simply feeling like they will not receive any support, so they don't even make the call.[327]

STAFFING AT PCH THAT DAY AND PRECEDING

263. It was acknowledged by CAHS that it was a busy day, with around 200 presentations to the PCH ED on 3 April 2021, which was 108% of the average presentation rate and

[323] T 569.
[324] T 571.
[325] Exhibit 1, Tab 27, p. 34.
[326] Exhibit 2, Tab 27.
[327] T 554.

higher than expected. In terms of their complexity and acuity, it was suggested it was not that different to other days, although I do note there were two resuscitations around the critical time, so the timing of those events is important, as well as the average number. At the time Aishwarya presented and then waited, the number of patients waiting to be seen was also around its peak, at 41, and the number remained around that mark until midnight.[328]

264. There are the official statistics showing the staffing levels available that day at PCH to manage the patient load presenting to the ED, and then there is the anecdotal evidence from the staff.

265. The official information provided indicated that on that day, all nursing shifts were fully staffed in the ED, noting that a variety of shift times were used with a mix of staff, including clinical nurses and registered nurses, as per usual staffing. It was noted that two rostered nurses had called in unwell and were replaced with nurses from the casual pool. Another registered nurse also left during her shift at 5.45 pm due to illness. This nurse was not replaced, noting that there was a Clinical Nurse Specialists rostered as a supernumerary (without a specific allocation of patients) who was available to assist.[329]

266. After 3 April 2021, a further review of workflows and staffing in the ED was undertaken and it was "acknowledged that the large floor layout and increasing activity and acuity created challenges to workflow in the ED. Workloads were also being impacted by COVID-19 infection control processes."[330] As a result, in April 2021 CAHS Executive approved a hospital wide increase in PCH Nursing establishment by 3.5% to cover high levels of parental leave and an increase in staff development nurses to support the educational needs of nursing staff, and in May 2021 CAHS Executive approved 16.28 additional nursing FTE's (Full Time Equivalent positions) for the ED. Additional clerical staff were also approved to reduce the need of clinical staff to undertake administrative duties. In addition, there was an increase of staff to implement a Triage Rapid Assessment Model to provide early senior medical assessment of patient, initiation of treatment and potential disposition decision immediately following triage during periods of high activity in the ED (although due to COVID the TRAM model hasn't continued).[331]

267. In August 2021 the CAHS Executive approved a further increase of just over 25 FTE to support a dedicated Resuscitation Team and increase staffing to support the Emergency Short Stay Unit.[332]

268. In summary, at the time of 3 April 2021, the Baseline Establishment for nursing in the ED was **76.8**. By the end of May 2021 it was **99.84** and by August 2021 it was **124.9**.[333]

---

[328] T 689 - 691; Exhibit 3.1, pp. 60 - 62.
[329] Exhibit 3.1, pp. 48 – 49.
[330] Exhibit 3.1, p. 51 [241].
[331] T 649; Exhibit 3.1, pp. 51 – 52.
[332] Exhibit 3.1, pp. 52.
[333] T 650; Exhibit 3.1, p. 53.

269. As for the doctors on shift on 3 April 2021, the information provided was that there were four extra junior medical officers (two Registrars and two RMO's or registered medical officers) allocated to work in the ED over and above the establishment. Evidence provided to the Court suggested this was because last-minute sick calls on the weekends and after-hours were difficult to find cover for, but also to supplement the ED workforce at times when it might be expected to be busy.[334]

270. Three RMO's called in sick on 3 April 2021, all for the afternoon and evening shifts. One of them was said to be a rostered 'extra' and therefore was said not to require backfilling. No formal request was made to the administration to seek additional staff from the central leave relief pool to replace the other two RMO's, so no efforts were made to replace them either.[335] It was stated that this meant "during the critical period of time that Aishwarya was in the ED (the first 30 minutes after her arrival at 5:35 PM) the base roster (or approved establishment) was exceeded by 3 JMO's until 6:00 PM and was at the base roster (approved establishment) until 8:00 PM."[336]

271. However, I note that shortly after Aishwarya's untimely sudden death a request was made to permanently increase the JMO establishment, and on 16 April 2021 CAHS reallocated 4.5 FTE paediatric registrars from the leave relief pool to the ED and in June 2021 CAHS approved an increased in junior medical officer workforce numbers for the ED of 6 additional registrars (inclusive of the 4.5 allocated in April) and 6 additional RMO's. There was also a significant increase in Consultant FTE in August 2021. A table provided by CAHS shows the changes in diagrammatic form:

	March 2021 FTE	August 2022 (current) FTE
Consultants	15.1	21.4 (plus 4.0 FTE for leave cover)
Fellows	2	2
ACEM trainee registrars	8	14
RACP trainee registrars	8	8
Core (non-training) registrars	4	4.25
RMOs	24	30

Exhibit 3.1, p. 43 [207].

272. What it shows is that, while it is correct to say that on the night of Aishwarya's death the ED was not technically short-staffed, despite a number of people calling in sick or leaving early, that is against the background that it had become apparent that the establishment roster was inadequate to deal with the demand.

273. This is supported by the factual evidence given by the staff who were working on 3 April 2021, as set out below, as well as the response by CAHS to increase the establishment in the months after April 2021.

[334] Exhibit 3.1, p. 39.
[335] Exhibit 3.1, pp. 38 – 40.
[336] Exhibit 3.1, p. 40 [195].

274. Dr Teo's impression was that the ED was understaffed at the start of his shift at 2.00 pm on 3 April 2021. It fluctuated a bit, but there were typically at least two consultants, at least two registrars and at least two residents working in the ED at any one time.[337] Dr Teo recalled there were two consultants working on this day when he started his shift, Dr Hollaway and Dr Sander, but not necessarily who else was on shift.

275. Dr Teo recalled that when he arrived he spoke to one of the consultants, who said words to the effect, "*It's busy, go there now and help out.*"[338] Dr Teo went straight to Pod C, and when he arrived there were between eight and ten patients there and only a resident doctor and himself. He set to work immediately and was busy for the rest of the shift.[339]

276. Dr Jack Dewsbury was an RMO working in the ED that evening and he had started at 6.00 pm. By that time, he was aware two of the other RMO's rostered to work had called in sick, which meant that he was allocated to assist the resuscitation team. He was otherwise there to see patients as usual. Dr Dewsbury hadn't been working there long, so he wasn't able to estimate if the shift was busier than usual, although it seems he was busy.[340]

277. Nurse Davies, the Shift Coordinator that afternoon, recalled the shift was "very busy,"[341] with 200 presentations to the ED recorded that day and about 98 of those presentations between 1.00 pm and 9.00 pm.[342] As previously noted, one nurse had to go home sick and that staff member wasn't replaced, so the other nurses simply covered their absence.[343] There was a category 1 patient resuscitation call at 6.00 pm, which drew staff off the floor, including Nurse Vining, and that then had a flow-on effect to the rest of the ED in terms of patient flow. Nurse Davies commented that paediatric nursing can be more challenging than other areas of nursing, as you are not dealing with just the patient but also their parents and other family members, and often the nurses "are not treated very nicely,"[344] particularly when there are delays and people become angry. This adds to the challenges of a busy night.

278. On this particular night, there were only 14 nurses available on the afternoon shift after the unwell nurse went home. Nurse Davies was asked her opinion of the adequacy of that number of nurses given the busyness of the ED, and she responded, "It's insane."[345] Nurse Davies explained that it was impossible. Nurse Davies noted the general aim was for approximately four patients to every one nurse, but on this shift she had calculated it was nine patients to every one nurse, which was "not sustainable."[346]

---

[337] Exhibit 1, Tab 13 [27],
[338] Exhibit 1, Tab 13 [88] – [90].
[339] Exhibit 1, Tab 13 [91] – [93].
[340] T 435.
[341] T 390; Exhibit 2, Tab 38.
[342] T 390; Exhibit 2, Tab 38 [13].
[343] T 390.
[344] T 391.
[345] T 392.
[346] T 393.

279. Nurse Davies could not recall if any request had been made on the night for extra staff to assist, which she agreed would have been her responsibility or that of the Clinical Nurse Specialist. However, she said frankly in her evidence: "To be honest, there's no point."[347] Nurse Davies explained that in her experience, the response from hospital clinical mangers would be, "I've got no staff here. There's nothing I can do."[348] Accordingly, she had given up requesting help generally. Nurse Davies believed she had probably advised the hospital manager that a nurse had gone home sick, but nothing more.[349] It was her experience that they were routinely faced with inadequate nursing numbers and insufficient experienced numbers to cope with the number of presentations, so unfortunately that night was no different to what they had been experiencing in the ED for some time despite repeated concerns being raised.[350]

280. Nurse Davies stated that around the time Aishwarya presented to the ED, she understood there were 67 patients in the ED and many of them were in the waiting room, waiting to be seen after being triaged, just like Aishwarya. Nurse Vining and Nurse Wills were responsible for all of those in the waiting room, which Nurse Davies called "a huge number."[351] On this particular shift, Nurse Davies was so busy that apart from her break, she was barely able to leave the co-ordinator's desk, so she was unable to help them. Nurse Davies, who had worked in the role of WRN prior to this date, noted that it was a very difficult role. It was not uncommon to assess a child and then never get back to them, just due to the reality of the busyness of the role.[352]

281. As I have set out earlier in this finding, there was evidence from Nurse Vining and other nurses on shift that evening about being staff being drawn away to cover resuscitations and to do one-to-one nursing specials, which left the remaining nurses with a heavy patient load that reduced their ability to spend time with patients. Nurse Vining had seen Aishwarya earlier than planned at the request of a ward clerk who had been approached by Aishwarya's parents, but due to being called away to assist with other duties, she never had time to return and execute her treatment plan.

282. All of these accounts support the general proposition that while technically the establishment staffing numbers were met on 3 April 2021, there were insufficient staff on the night to manage the presenting patient load in a timely, effective and safe way. In particular, and very relevant to this case, there were insufficient nurses available to monitor the patients who were waiting in the ED waiting room as the nurses were spread thinly and had to assist with resuscitations and duties in the pods.

283. Dr Wood conceded that 'the experience of the staff and how busy it feels is very different to what the numbers might say"[353] and he agreed that their perception of the busyness of the ED is relevant to patient care. The significant efforts made by CAHS to recruit extra staff before this night, and the changes made by CAHS to the base

---

[347] T 393.
[348] T 394.
[349] T 394.
[350] Exhibit 2, Tab 38.
[351] Exhibit 2, Tab 38 [16].
[352] T 392.
[353] T 692.

staffing in the ED following these events, supports the conclusion that the staff were stretched and under pressure on the night in question.

ROOT CAUSE ANALYSIS (SAC 1)

284. Aishwarya's sudden death at PCH was investigated through a Root Cause Analysis inquiry process. These kinds of internal inquiries are conducted in cases where there is a clinical incident that has, or could have, caused serious harm or death attributable to health care provision (or lack thereof) rather than the underlying condition or illness of the patient.[354] The circumstances of Aishwarya's death were felt to fall within that category and a SAC1 notification was made on 6 April 2021. Once the incident was reported, an internal investigation was required to be commenced and completed within set timeframe of 28 days, unless there is an extension. Such an investigation did take place in April and May 2021 and a report was prepared by the panel of experts involved in the inquiry and completed on 19 May 2021.[355] The focus of the report is on identifying opportunities to improve and to ensure better outcomes in the future, rather than any focus on blame in relation to the staff involved in Aishwarya's death.

285. The next step would ordinarily be for the Chief Executive Officer of CAHS (Dr Anwar at that time) and other members of the Executive of CAHS to sign the panel's completed report before having it sent to the WA Health Patient Safety Surveillance Unit. That did not occur in this case.

286. The Root Cause Analysis was not endorsed by the PCH Executive, which caused some controversy. Dr Anwar commented in his evidence that the "focus is on honesty, transparency and learning"[356] and explained that the normal process of a Root Cause Analysis would be for the senior leaders in the organisation to get an opportunity to review the report after the matter has been investigated and written up, including any recommendations. In this case, he said that the "the scrutiny that's required between the leadership team and the investigating team didn't occur."[357] Therefore, the management team went to the Department of Health and said there were elements within the report that had not been adequately explored and they wanted it subject to greater scrutiny, without seeking to censor the report. Dr Anwar said in evidence that in the interim, they accepted all of the 11 recommendations and began to try to implement them, to ensure that there was no risk of a further adverse event in the meantime due to the lack of finality over the Root Cause Analysis report.[358]

287. Dr Anwar clarified that all of the 11 recommendations from the Root Cause Analysis were accepted without modification, but some of the contents of the report were in issue.[359]

288. Many other witnesses who were working at PCH on the relevant night indicated that they were interviewed as part of the Root Cause Analysis but were not give an

---

[354] Severity assessment code (SAC) 1 clinical incidents (health.wa.gov.au).
[355] Exhibit 2, Tab 25 and Tab 26.
[356] T 35.
[357] T 35.
[358] T 35 - 36.
[359] T 69 -70.

opportunity to review the summary of their interview before the report was finalised. They felt there were errors in the summary when they later received and reviewed it.[360]

289. Some of this is, no doubt, attributable to the speed at which the investigation had to be conducted and concluded.

290. The Independent Inquiry, which I refer to below, also noted that while findings are at times discussed in the media, it is imperative that the staff and consumers participating in the process feel confident in the process.[361]

291. Dr Nair commented in his evidence upon his impression of how traumatised the staff were by the Root Cause Analysis process and that a lot of the staff felt unsupported when interviewed. He observed that in Queensland they have a psychologist sit in during the interview process, which he found to be an amazing addition in terms of providing support for the staff. That is, perhaps, something for WA Health to consider in providing guidance to hospitals as to how to conduct these proceedings, particularly in extremely traumatic cases such as this one.[362]

292. The problems with the Root Cause Analysis process were compounded by the fact that, unusually, the report was released publicly by the media, subjecting all involved to unprecedented scrutiny and criticism. The fact the CAHS Executive had not signed the Root Cause Analysis report led to negative feedback and created concerns for Aishwarya's parents and the public about the process.[363]

293. After the Root Cause Analysis into Aishwarya's death concluded, some practitioners were reported to the Australian Health Practitioner Regulation Agency (Ahpra) by the CAHS Executive based upon a view as to the actions they did, or did not take on the night in relation to Aishwarya's care.[364]

294. In response, the Australian Medical Association and the ANF took the unprecedented step of referring some CAHS executives to Ahpra. Mr Olson indicated this was done by the ANF so that the Nursing and Midwifery Board and Ahpra "would be able to assess the whole picture and context of the tragic shift on 3 April 2021 in which those junior nurses found themselves."[365] It is not my place to go into any detail about the Ahpra investigations, which are separate to this inquiry. However, much of this information seems to have made its way into the public domain separate to this coronial inquiry, so I simply note at this stage my understanding is that all but one referral has been resolved without any further action being taken, no registered health practitioners are subject to any ongoing conditions on their registration in connection with Aishwarya's death and the one pending matter is anticipated to be resolved once this coronial inquiry is completed.[366]

[360] T 124, 191, 263, 304 – 305, 313, 398.
[361] Exhibit 2, Tab 29, p. 23.
[362] T 552.
[363] Exhibit 2, Tab 29, p. 28.
[364] T 71; 83; Exhibit 3.1.
[365] Exhibit 2, Tab 39 [42].
[366] Nursing bosses to face national watchdog over their role in Aishwarya's death (watoday.com.au).

NURSES' 10-POINT PLAN

295. Mr Mark Olson is the former long-term Secretary of the Australian Nursing Federation, Industrial Union of Workers (AND) and at the time of the inquest he was the Branch Secretary of the WA Branch and the Chief Executive Officer of that organisation and gave evidence on behalf of the ANF at the inquest. Mr Olson is a qualified registered nurse, who still maintains registration, so he speaks about issues relating to nurses from the perspective of his own personal experience as well as from the perspective of the union representing nurses.

296. Mr Olson was able to provide some background to the Court about nursing workloads at PCH at the relevant time leading up to Aishwarya's death from the perspective of the nurses. Nurses working in the ED at PCH had raised a number of concerns in the previous months. On 15 February 2021, Mr Olson received a letter from Dr Simon Wood, the then Acting Chief Executive of CAHS referring to the workload grievances that had been received from the ED at PCH. The Executive acknowledged that 2020, and the start of 2021, had proven exceptionally difficult to forward plan due to an unprecedented increase in emergency presentations, amongst other things, and he assured Mr Olson that they had implemented a number of measures to improve the workload of staff. Dr Wood acknowledged that there was a need to fill vacancies as a result of resignations and replacing unplanned leave was a continued challenge with the reduced pool of casual nurses. Dr Wood also acknowledged there had been issues providing professional development to all nurses, although there were continuing efforts to ensure staff could utilise their professional development hours.[367]

297. Approximately three weeks after that letter was sent, on 9 March 2021, Mr Olson personally received an email from a Clinical Nurse working in PCH Emergency Department raising serious safety concerns. The nurse told Mr Olson they were writing to him as they had "grave concerns regarding the staffing levels and safety"[368] within the department. They told Mr Olson there had been several incidents resulting in significant harm to patients in the previous few months (although no specific detail was provided) and after speaking to their colleagues, decided to write to Mr Olson as they felt anxious about working in the department "knowing that they cannot deliver adequate care to all of their patients."[369]

298. In the letter, the nurse provided existing staffing numbers and referred to the fact that some of the nurses would be pulled away in the event of a resuscitation, which could at times leave "as few as 2 nurses to care for the rest of the department – often 40-60 patients."[370] They described their nursing colleagues "taking increased sick leave due to stress and burnout, however they are frequently not replaced by casual pool staff,"[371] so the absent staff are regularly left unreplaced. At the time of writing the email, the nurse referred to attempts by the Clinical Nurse Manager to ask for more nursing staff, without any obvious progress, and a planned meeting with Dr Anwar that had been postponed twice before he had then stepped away from the role of Chief

[367] Exhibit 2, Tab 39, Attachment 5.
[368] Exhibit 2, Tab 39, Attachment 1, p. 1.
[369] Exhibit 2, Tab 39, Attachment 1, p. 1.
[370] Exhibit 2, Tab 39, Attachment 1, p. 1.
[371] Exhibit 2, Tab 39, Attachment 1, p. 1.

Executive, with no concrete commitment from the remaining executive team to hold the meeting in the future.[372] The nurse stated their belief that the concerns of the PCH ED nurses were "consistently downplayed, dismissed or outright ignored by the executive team" and sought the ANF's representation and advocacy on their behalf.[373]

299. Mr Olson gave evidence that he took the concerns raised in the email very seriously and responded quickly by making arrangements to discuss the concerns further with the PCH ED nurses at a meeting that took place on 29 March 2021. It was apparent to him that the nurses had already been attempting to raise their concerns with the Executive, but had been unsuccessful. Mr Olson personally met with the nurses to discuss how they wanted the ANF to assist them with improving staffing levels and alleviating their safety concerns. During the one hour meeting, the nurses raised safety for both patients and staff as their primary concern. Mr Olson recalled at the inquest that he was overwhelmed at the time by the nurses' "desperation"[374] for help. The nurses referred to:[375]

- a history of steadily increasing presentations with further periods of 'surges' in presentations;
- an increase in acuity of patients;
- a huge increase in mental health and behavioural disorders in patients;
- a massive increase in access/bed block;
- the fact the ED often was not running at allocated staffing levels due to staff being on sick leave or resigning, with no casual or relief staff available to replace them; and
- continued rolling contracts for the majority of newer staff, with the lack of access to permanency contributing to further staff loss and low morale;

300. There was reference to a gastroenteritis outbreak in September/October 2020, followed at the end of the year by the unprecedented RSV outbreak referred to by Dr Anwar, which led to large numbers of presentations, mainly late in the evenings. There was a brief lull in January, but then it had reverted to surging presentations in February and March 2021. The staff had raised concerns with Dr Anwar but meetings to discuss the problem had been delayed and the nurses felt like the executive were "waiting for the problem to go away."[376]

301. Complaints were raised about the staffing levels, as the staffing numbers included the shift coordinator and triage nurse, even though they were not able to take a patient load. Further, two nurses were allocated to the Emergency Short Stay Unit (ESSU) capped at 10 patients, which often meant that the main acute pods of the ED had a total of seven nurses in the morning and night shift, of which often four of those nurses were pulled away to assist with resuscitation, leaving only three nurses to cover the rest of the patients in the ED, which was often in the order of 70+ patients. As a result, there were frequently not enough staff on the floor to manage the number and acuity of patients. The need to take away nursing staff to cover resuscitations was

[372] Exhibit 2, Tab 39, Attachment 1, p. 1.
[373] Exhibit 2, Tab 39, Attachment 1, p. 2.
[374] T 580.
[375] Exhibit 2, Tab 39, Attachment 2.
[376] Exhibit 2, Tab 39, Attachment 2.

frequently referred to as a major contributor to these issues. The need for mental health patients, who were increasing in number, to have one to one nurse specialling also caused staffing issues. The nurses told Mr Olson that some of the gaps in staffing numbers were being filled by staff doing double shifts and extra shifts, and they were often unable to take breaks.[377] Reference was also made to junior and new staff not being supported as the senior nurses, such as the clinical nurse specialist, were having to focus on their own patient loads, which had led to less education and support during shifts and a subsequent rise in errors and near misses.[378]

302. The nurses reported there had been an increase in SAC1 events, and the Root Cause Analysis investigations had found that insufficient nursing staff was a contributor. The nurses emphasised to Mr Olson their belief that patient care and safety was being affected by these issues. Mr Olson was told that doctors were expressing concern about the lack of nurses on a daily basis and they were running out of room in the waiting room for patients and their carers, even though they were restricting the number of visitors accompanying a patient.[379]

303. Mr Olson's notes of the meeting record the nurses asked that the ANF advocate for the same patient ratios that exist in the Victorian Children's Hospital Emergency Departments, including the shift coordinator and triage nurse not included in floor numbers, and a supernumerary resuscitation team with a minimum of four nurses allocated to it, who could also assist floor staff with category 2 patients and patients with behavioural problems when not required for resuscitations.[380] Other suggestions included a clearly articulated and distributed Winter/Surge Bed Management Strategy, the opening up further of other units to reduce access block, fast track recruitment of new staff and a specifically trained paediatric security team to be based in the ED.[381]

304. Currently, the WA model for nurse staffing levels in public hospitals is based on a nursing hours per patient per day formula. The criticism of this model is that it is said to be complicated and not transparent. It is very clear that, instead, the nurses want fixed nurse to patient ratios to apply, as is the case in many parts of the Eastern States[382] It was suggested by Mr Olson that the standard model is generally one nurse to every three patients (1:3).[383]

305. At the conclusion of the meeting on 29 March 2021, Mr Olson stated that the nursing staff agreed that he would formulate a campaign involving the media, letters to the Health Minister and other non-industrial activities for the nurses as the nurses were explicit that they did not want industrial action to form part of the plan.[384]

[377] Exhibit 2, Tab 39, Attachment 2.
[378] Exhibit 2, Tab 39, Attachment 2.
[379] Exhibit 2, Tab 39, Attachment 2.
[380] Exhibit 2, Tab 39, Attachment 2.
[381] Exhibit 2, Tab 39, Attachment 2.
[382] Exhibit 2, Tab 39, [23], [25].
[383] Exhibit 2, Tab 39, [24] and Attachment 3.
[384] T 581; Exhibit 2, Tab 39 [31] – [32].

306. Earlier on the day of the meeting, Mr Olson had spoken with the then Health Minister and informed him of the concerns raised about the PCH ED and the fact he was having a meeting with the nurses that day.[385]

307. Five days after that meeting, during which the nurses had raised their grave concerns about the safety of patients in the current working conditions, Aishwarya died. The nurses worst fears had come to pass. Mr Olson was informed of Aishwarya's tragic death that day. In the following days, with the input of nurses from the PCH ED, the ANF developed the 'ANF 10-point plan' that is referred to in the Inquiry report. The plan was completed on 5 April 2021, and after being distributed to staff for final approval that day, was sent to the Health Minister on 6 April 2021.[386]

308. As noted above, after nurses were referred to Ahpra, members of the CAHS Executive were also referred to Ahpra by the ANF. I note Mr Olson and the other members of the ANF Council and membership generally submitted that there was a dire nursing staffing situation in place in the PCH ED prior to, as well as on, 3 April 2021, that was known to the Executive but had not been addressed.[387]

309. Immediately following Aishwarya's death, Mr Olson and other ANF staff worked with nurses to develop the ANF 10-point Plan to try to resolve some of the nurses' concerns that had been raised at the meeting on 29 March 2021 and others that had crystallised in the wake of this tragedy. The plan set out:[388]

1. Nurse to Patient ratio 1:3;
2. Shift coordinators and triage nurses not be included in floor numbers;
3. Supernumerary resuscitation team;
4. Establish an ED Consultative Working Group, including nursing representation;
5. Double the number of staff development nurses to help educate , train and support the graduate nurses;
6. Paediatric Critical Care Unit, opening to its full capacity;
7. Clearly articulated winter surge bed management strategy;
8. Fast track recruitment process;
9. Establishment of a 24/7 Medical Short Stay Unit; and
10. Additional numbers of specifically paediatric security staff for PCH.

310. There was evidence given that all but point one were generally accepted by the CAHS Executive, with some modifications. The nurse to patient ratio model was the contentious point, with the ANF seeking to align WA with a model used in other Australian jurisdictions and WA Health wishing to retain its nursing hours model. I come to that specifically later in this finding.

311. In terms of general concerns about staffing numbers, Mr Olson accepted in his evidence that nursing numbers did increase dramatically after Aishwarya passed away.

---

[385] Exhibit 2, Tab 39 [33].
[386] Exhibit 2, Tab 39 [34] – [39].
[387] Exhibit 2, Tab 39 [42].
[388] T 603.

However, he also gave evidence at the inquest that he was still receiving emails from staff in September 2022 describing staff deficiencies in the emergency department.[389]

312. Mr Olson also gave evidence that while CAHS supported the third point, seeking a dedicated resuscitation team, it had not been implemented by the time of the inquest. Mr Olson acknowledged that the reason for the delay given by CAHS was an inability to recruit sufficient staff, but he also suggested that there were ways that staff could be recruited, and the ANF had made suggestions to assist in recruitment that CAHS had not implemented.[390] Mr Olson gave evidence that he had done a number of press conferences in December 2020 and made suggestions to the government that were not taken up.

313. On 9 August 2021, the ANF released a Recruitment Plan 3.0 to hopefully assist the government with future nursing recruitment, that might fill some of these gaps.[391]

INQUIRY

314. Following a recommendation of the Root Cause Analysis, and on the direction of the Minister for Health (WA), the Director General of the Department of Health initiated an independent Inquiry under s 183 of the *Health Services Act 2016* (WA), which was conducted by the Australian Commission of Safety and Quality in Health Care (ACSQHC), led by Emeritus Professor Les White and supported by a panel whose expertise included paediatrics, emergency medicine, nursing, psychology and the management of hospitals.[392] Dr Anwar submitted those who comprised the Independent Inquiry Team "were uniquely qualified to address the matters reposed in them."[393]

315. A representative for Aishwarya's family was included in the Inquiry team and members of the Inquiry team met with Aishwarya's parents along with their family representative to provide them with an opportunity to add their perspective to the process and provide specific complaints and feedback. It was noted that Aishwarya's parents continued to express a "deep sense of disbelief"[394] that the warning signs could have been missed and a death of a child could happen at a hospital in this State in such a way.[395] Like others, they indicated their disagreement with many aspects of the Root Cause Analysis that preceded this Inquiry, "along with persistent feelings of distrust in the system."[396] While the Inquiry team found the Root Cause Analysis by the panel had been robust and diligent, it was acknowledged that open disclosure and communication with Aishwarya's family had proven difficult after the events, resulting in this breakdown of trust, which had exacerbated Aswath and Prasitha's grief.[397]

[389] T 586 – 589.
[390] T 583 - 584.
[391] Exhibit 1, Tab 39.4.
[392] Exhibit 2, Tab 29.
[393] Exhibit 2, Tab 46 [1].
[394] Exhibit 2, Tab 29, p. 5.
[395] Exhibit 2, Tab 29.
[396] Exhibit 2, Tab 29, p. 6 - 8.
[397] Exhibit 2, Tab 29.

316. The Inquiry also noted that historic tensions between the Executive team and the clinical workforce, with particular emphasis on the ED, were rekindled by the discord over the Executive team's management of the Root Cause Analysis report and referrals of clinical staff to Ahpra. The Inquiry team learnt of the huge impact Aishwarya's death had has had on the morale of all staff and the limited communication with the Executive, along with anger and confusion regarding the Aphra referrals, had led to an undermining of trust in the workplace.[398]

317. The Inquiry report refers to the Root Cause Analysis process in this case as "unusual and highly challenging,"[399] noting the "extraordinary handling of the report, most notably the absence of Executive team endorsement, along with the later referrals of staff to … Ahpra, the unexpected release to the media and the public scrutiny, did much to damage trust and morale at PCH."[400]

318. It is apparent the Inquiry team appreciated keenly the damage caused to Aishwarya's parents and PCH staff from the fallout of the Root Cause Analysis, and while their recommendations are intended to be read in conjunction with the Root Cause Analysis recommendations, many of the Inquiry recommendations are focussing upon healing the rifts and restoring trust, ensuring that staff and families now and in the future feel heard and supported.

319. The Inquiry report was provided to the Minister on 8 November 2021 and was tabled in Parliament, as required by the *Health Services Act*. The Inquiry recognised the extraordinary toll Aishwarya's death has had on her family, as well as on the PCH staff and wider health care community. Moving forward, the report contained 30 recommendations. The recommendations covered key areas such as sepsis identification, parent escalation, consumer engagement, clinical governance, workplace planning and supply and organisational culture. CAHS and the Department of Health subsequently accepted all 30 recommendations and have since been taking steps to implement them.[401]

320. The Inquiry Report referred to the Root Cause Analysis Report and recommendations and the ANF 10-point Plan and added its support to those, as well as then making 30 further recommendations. I do not propose to go through the Inquiry's recommendations here in any detail, as they are available publicly in that document. However, there are some features of the Report and responses to it that I wish to highlight.

321. Nurse Hanbury was asked about comments that were made in the Inquiry, relating to Aishwarya's parents feeling staff in the waiting room avoided eye contact with them (noting that there was no suggestion Nurse Hanbury was one of those staff members). Nurse Hanbury said that while she does not believe anyone deliberately tries to avoid eye contact with parents in the waiting room, she felt at some point "you're just a bit overwhelmed or you are trying to do your seventh bit of notes for the kid that you did

[398] Exhibit 2, Tab 29, pp. 10, 33.
[399] Exhibit 2, Tab 29, p. 6.
[400] Exhibit 2, Tab 29, p. 6.
[401] Exhibit 2, Tab 29.

see an hour ago …. and you know that someone is hovering above you with more things or more questions."[402] This was a frank acknowledgment in the context of the competing demands that are placed on nurses in the ED and how it can impact on their ability to be receptive to unplanned interactions with family members while they are stretched so thin. Nurse Hanbury could actually be seen on the CCTV footage interacting with other families as she went about her tasks, which she appeared to do courteously and appropriately, but it is obvious that it was an additional challenge added to the various tasks they were expected to perform. The need to document was an obvious burden on the nurses, with difficulty getting access to a computer or finding the hard copy notes at times, which meant "you get it as quick as you can and document all your notes if you can find them."[403]

322. During the Inquiry, evidence was also given that the ED staff at PCH were exhausted, demoralised and relatively isolated at the time of Aishwarya's death. It was noted in the Inquiry report that that during the last quarter of 2020, the PCH ED transiently became the single busiest paediatric emergency department in the nation and there is data to suggest that PCH has shown the highest numbers of presentations per nursing FTE over the past two years. It is, therefore, not surprising that the staff have felt this way.[404]

323. Nurse Taylor gave evidence "the whole department was running under a lot of pressure, time pressure and exhaustion."[405] The staff had "a long period of fatigue where [they] had requested more resources"[406] but none had arrived. PCH staff were asked at the inquest whether that terminology still applied to the hospital or whether there had been changes in the culture at PCH ED since that time. Nurse Taylor indicated that, prior to going on parental leave in January 2022, she had noticed there was an increase in staffing numbers but the way the resources were obtained was less than ideal. Most of those roles were filled by nurses doing double shifts, which meant people were actually more exhausted as they were working more hours and she felt it was unsustainable moving forward and those additional roles needed to be filled by recruitment of new staff.[407]

324. Dr Hollaway said he believes that he works with some of the best and kindest doctors and nurses but they were all "completely exhausted" in April 2021. They had experienced their busiest winter ever, with up to 300 patients presenting a day when they were staffed for about half that amount, and then as they continued through to March, it was their busiest March ever on record. So by April, Dr Hollaway said, "We [408]definitely felt like we were under the pump and there was no end in sight."[409]

325. Dr Hollaway gave evidence that they were short of doctors, but primarily they needed more nurses and the doctors were very concerned for their nursing colleagues. He had sat in on a meeting with the executive where medical staff had highlighted those

[402] T 380.
[403] T 380.
[404] Exhibit 2, Tab 29, p. 11.
[405] T 125.
[406] T 125.
[407] T 123 - 124.
[408] T 339.
[409] T 339.

concerns. Like the nurses, the medical staff did not feel things were happening, or happening fast enough, in response to the raising of those concerns.[410]

326. The Inquiry Team acknowledged in the Inquiry Report that the WA Government had made significant investments in hospitals, health and mental health services in 2021-2022 State Budget to help address the unprecedented demand on WA's health and mental health system, which will have some benefits specific to CAHS. However, things such as the culture of the organisation, are less easily fixed by money alone.

327. I note that a Response to the Inquiry Report from the Board Chair of CAHS, Dr Rosanna Capolingua, was provided with the documentation. Dr Capolingua acknowledged that the Inquiry found the organisational culture was considered as a backdrop to the tragic death of Aishwarya and expressed dismay that Aishwarya's family reported to the Inquiry they had experienced defensiveness from PCH. Dr Capolingua indicated on behalf of the CAHS Board that they are "determined to overcome any defensiveness in the organisation which we believe is a barrier to true reflection, humility, insight and responsive improvement"[411] and reinforce the culture that is driven by putting the patient first. Dr Capolingua expressed the CAHS Board's understanding that in "order to move forward, PCH also needs to heal."[412] This requires a unification of all parts of the organisation from Executive, through clinical staff down to the support staff who help the place as a whole to keep functioning. Dr Capolingua referred to the commitment of CAHS to honour the memory of Aishwarya "with a commitment to improve and embed a culture of learning and clinical excellence."[413]

328. That is an admirable sentiment, but it must be backed up by the other commitments the Executive has made in terms of supporting the staff at PCH to do their jobs safely and well. That means finding innovative ways to resolve the ongoing staffing shortages and communicating those steps from the Executive down to the coalface, so that the staff understand that their concerns have been heard and recognised, that they are valued and that there is light at the end of the tunnel. If this doesn't occur, then more nurses and doctors will choose to leave, either PCH or the profession as a whole, which is something the WA community cannot afford.

329. With that in mind, it is worth setting out some of the information provided about the many steps that were being taken by the CAHS Executive prior to 3 April 2021, as well as after, to try and deal with the increasing pressure on the hospital, and in particular the PCH ED.

RESPONSE BY CAHS PRIOR TO AND AFTER 3 APRIL 2021

330. I note that the inquiries above looked into many of the systemic issues that were affecting PCH at the time leading up to these events. During the inquest, a considerable amount of information was also provided to me to demonstrate that the

[410] T 345.
[411] Exhibit 2, Tab 29, Letter to Dr Russell-Weisz dated 8 November 2021.
[412] Exhibit 2, Tab 29, Letter to Dr Russell-Weisz dated 8 November 2021.
[413] Exhibit 2, Tab 29, Letter to Dr Russell-Weisz dated 8 November 2021.

CAHS Executive, and management at PCH were aware of the staffing issues leading up to 3 April 2021 and were actively trying to resolve the problem. Following Aishwarya's death, immediate further steps were then taken, and information was also provided about those actions.

331. Dr Aresh Anwar was, until shortly before the inquest, the Chief Executive of CAHS. Dr Anwar had been appointed to the role in an acting capacity in August 2018 and was later made permanent. He remained in the role until 12 August 2022, although he was seconded to the Department of Health for a period between 15 February and 19 April 2021 to lead the COVID Vaccination Program. This period of secondment encompassed 3 April 2021, so Dr Anwar was not actively managing CAHS on the day of Aishwarya's tragic death. However, he had been involved in the attempts to resolve staffing issues in the lead up to this period, and returned to the active role of Chief Executive of CAHS shortly afterwards, so he was still in a position to speak about all the events and he felt the impact of Aishwarya's death on a personal level.[414]

332. Dr Anwar commented that "although it pales in comparison to the experience of many of others, Aishwarya's death has had a profound and professional impact"[415] on him. He stated he had not spent a single day since Aishwarya's death "without thought of her, without reflection upon how the tragedy of her death could have been prevented and about changes that might be implemented to ensure no other child in her position dies or comes to harm."[416] Dr Anwar said in evidence that sometimes he even wakes in the middle of the night and thinks what "we could have done differently to have a different outcome."[417] Dr Anwar impressed me with the sincerity of his deep regret that Aishwarya's family have suffered this tragedy and wishing to learn from these sad events to ensure that PCH is a safer place in the future. Dr Anwar emphasised that he was not seeking in his evidence to give excuses, but rather to provide an explanation for some of the known circumstances leading up to Aishwarya's death.

333. Dr Anwar had been involved in the planning and implementation of the move from Princess Margaret Hospital into PCH. Dr Anwar acknowledged that there had been historical challenges with the children's health service at PMH and after the move to PCH, and while some of those challenges resolved, new ones presented in their place. In particular, there were the challenges of working in a new building, the unprecedented pressures of the COVID pandemic and its associated workforce challenges, as well as changing patterns in patient presentations at PCH.[418]

334. Initially, at the start of the pandemic there had been a reduction in the number of presentations to the PCH ED and a reduction in the number of elective surgical cases that were taking place, which reduced the requirement for staff. However, the number of presentations then started to rise in June 2020 and, contrary to the usual pattern, did not reduce again over summer. Usually, staff would be taking breaks over the Christmas period, but in late 2020 the anticipated reduction of cases over Christmas didn't happen, which meant some staff could not take leave, and those who remained

[414] Exhibit 2, Tab 46.
[415] Exhibit 2, Tab 46 [3].
[416] Exhibit 2, Tab 46 [4].
[417] T 26.
[418] Exhibit 2, Tab 46.

behind were under increased pressure. Dr Anwar explained that there were a few factors behind the change in the number of presentations, noting a spike in children presenting with RSV (respiratory syncytial virus), as well as a marked increase in the number of children with mental illness, in particular eating disorders. This was apparently a worldwide phenomenon during the pandemic, and it was noted that these types of patients take a lot of intensive time to manage their care properly. Further, there was inexplicably an increase in newly diagnosed cancers in children, which obviously is a priority.[419]

335. Therefore, in December 2020, Dr Anwar said PCH had "a very, very unique set of circumstances where we had a persistent high pressure of presentations at a time of year where we would traditionally have expected the hospital to be at its quietest."[420] Staffing is usually patterned on historical data, so the changes in patient numbers was not adequately catered for in the usual staffing rosters for that time of year. Dr Anwar gave evidence that the hospital was monitoring presentations and was acutely aware of the changing patterns, but the thing that changed at that time and into early 2021 as the pressure continued, was the ability to respond.[421]

336. There was evidence at the inquest that the hospital trialled a number of ways to reduce the pressure on the ED, separate to increasing nursing staff, such as sending children to secondary sites where appropriate and utilising AIN's (Assistant in Nursing) to free up nurses time, putting in a new model for eating disorder patients utilising an emergency telehealth system to reduce attendance at hospital if it was safe to do so and creating a larger ward for those patients who required admission, cancelling some low acuity elective surgery and increasing nursing hours in some of the wards. However, it was still becoming more and more difficult to backfill shifts.[422]

337. There was evidence nursing staff were raising their concerns with the Executive,[423] and Dr Anwar stated he had raised concerns with the Department of Health in December 2020 around the real challenges PCH was facing in making sure that staffing numbers matched the scale of demand, given the particularly acute challenges they were facing at that time due to the real rise in RSV presentations. Dr Anwar explained that the West Australian Emergency Access Target (WEAT) also often referred to as the '4 hour rule' was a surrogate marker of how they were operating and as a performance measure they were not meeting it.[424] The purpose of the meeting was not to ask for more funding, but rather to highlight the problem and see if any further strategies could be suggested to try to get more nursing staff into the organisation.[425]

338. Dr Anwar acknowledged that he was aware by the end of 2020 and start of 2021 that nurses had raised concerns that were twofold. One was that the number of children that were presenting at that time was not being matched with the number of staff that

[419] T 29 – 30, 40, 642, 688; Exhibit 3.1, pp. 66 – 67.
[420] T 30.
[421] T 30.
[422] T 643 – 644, 687 - 688.
[423] T 643.
[424] T 66.
[425] T 79.

they felt needed to be deployed within the ED to keep a watchful eye right across all areas, "so a staff-child ratio."[426] The other concern was their workloads generally.[427]

339. Dr Anwar noted that PCH was particularly vulnerable to staffing issues arising from COVID as the PCH nursing model was heavily reliant on casual nursing staff, who quickly became absorbed into other COVID related roles and were no longer available as a pool to fill roles at PCH once demand increased. Border restrictions prevented recruitment from interstate or overseas nurses, which would often have been the other means by which new staff would be found. Accordingly, when there was a dramatic increase in activity levels at PCH, there was no pool of new nurses to fill the need for additional nursing staff, particularly the kind of nurses with paediatric experience who were traditionally recruited by PCH.[428]

340. A consistent feature of the evidence of many of the PCH nursing and medical staff who gave evidence at the inquest was the feeling that, prior to Aishwarya's death, they had been raising genuine concerns that they were understaffed and stretched to breaking point, but these concerns were ignored by the Executive. In a report prepared for the inquest, it was acknowledged by CAHS that the ED nursing staff did raise concerns about their ability to manage the ED workloads in December 2020, noting that 16 ANF workload grievances and three ANF Nursing Practice Risk forms were submitted to the ED Clinical Nurse Manager during December 2020. However, CAHS submitted that at the time of receiving the grievances, they had already put strategies in place to try to respond to the pressures on the staff and improve staffing levels.[429]

341. Dr Anwar acknowledged that a question might be raised as to whether the scale of the response of the Executive was commensurate with the concerns that were being raised, but he denied that the response of the organisation was simply one of passivity, with no attempt to respond at all to the concerns.[430]

342. Dr Anwar gave evidence that he had signed off on a briefing note around increasing the nursing profile in February 2021, so there were discussion about increasing the FTE and around recruitment and changes in the nursing profile at that stage, well before the events on 3 April 2021.[431] Another witness spoke to CAHS having undertaken 62 recruitment processes between November 2020 and July 2021 in the end, to try to staff the ED and inpatient beds in wards as well as across the organisation, but the results were limited.[432]

343. Dr Anwar gave evidence that "despite a desire to recruit, we were unable to fill our posts."[433] As a result, PCH had to change the way they recruited in order to increase the pool of staff available, such as no longer requiring paediatric experience and instead opting to try to recruit staff with experience in the adult sphere and then putting them through a structured introduction into infant, paediatric and adolescent

[426] T 75.
[427] T 75.
[428] T 30 – 31; Exhibit 2, Tab 46.
[429] Exhibit 3.1, p. 47.
[430] T 27; Exhibit 2, Tab 46.
[431] T 65.
[432] T 644, 652; Exhibit 3.1, p. 54 [248].
[433] T 31.

nursing (SIPAN).[434] However, I note that this change was not introduced until after Aishwarya's death.[435]

344. Prior to introducing SIPAN, and before Aishwarya's tragic death, PCH had looked at other ways to increasing the pool of nurses available, such as releasing nursing staff and other professionals who were not involved in direct patient care from those duties, in order to help support the other nurses providing that direct care. Other steps were taken to reduce the patient load wherever possible, such as increasing the number of ward rounds in order to facilitate movement of patients and also to reduce the number of elective surgeries to create capacity. Study days and non-critical education sessions were also cancelled.[436]

345. Some of these changes had obvious downsides, but Dr Anwar described the process as not trying to make "a good decision"[437] but rather the Executive "making the least bad decision"[438] at the time, with a focus on having the least negative impact on children and families. For example, the reduced education days was seen as a necessary evil in the fact of the pressures and acute risks, "with knowledge that education occurs over a period of time."[439]

346. Evidence also pointed to one of the problems being that the recruitment process itself was lengthy and frustrating, so steps were taken to centralise the recruitment process and expedite the process.[440]

347. Dr Anwar gave evidence that all of these changes had small impacts on the number of staff required,[441] but he accepted that overall the clinical staff, particularly the nursing staff, were feeling distressed and overwhelmed on a regular basis, particularly in the Emergency Department. Dr Anwar gave evidence he had met with staff in the Emergency Department and they "definitely raised concerns"[442] with him and other members of the leadership team and there were a number of strategies that were put in place immediately to try and help mitigate some of the pressures. The concerns were escalated to the Department of Health and Dr Anwar gave evidence that he personally rang the Chief Nursing and Midwifery Office to say that they were facing a real challenge and to ask if they had any suggestions on how to address it. He recalled that he "got acknowledgment that there was a challenge across the system" and that the Department was also looking at short, medium and long term mitigations.[443]

348. Dr Anwar said in his evidence that it was "anxiety-provoking"[444] to know that staff were raising concerns and demand was outstripping capacity in terms of staffing, but there were few options to quickly solve the problem. He noted that there was an

[434] T 31.
[435] T 32.
[436] T 32, 40, 645; Exhibit 3.1.
[437] T 41.
[438] T 41.
[439] T 41, 86.
[440] T 646.
[441] T 32.
[442] T 42.
[443] T 42.
[444] T 43.

"absolute organisation-wide collective effort to look at how we could do things differently" but in all honesty, even looking back in hindsight, it's not clear what could have been done at that time other than perhaps an earlier roll out of the SIPAN project to recruit nurses without paediatric experience.[445]

349. Dr Anwar accepted that one way PCH resorted to solving the staffing issues prior to Aishwarya's death was to rely upon staff doing extra shifts. He noted that the PCH staff are very dedicated and acknowledged that the majority of the staff who were doing those double shifts and extra shifts were motivated by ensuring the organisation could provide safe care and supporting their colleagues, rather than financial gain. Dr Anwar agreed that this would have added to their exhaustion and noted that looking back it is important to acknowledge the dedication of the staff to children and families, volunteering to do double shifts and cover their colleagues in spite of how they were feeling.[446]

350. Other evidence provided on behalf of CAHS at the inquest also conceded that the multiple recruitments undertaken leading up to April 2021 did not increase total FTE's substantially, with many positions simply filled with existing PCH staff moving from fixed term to permanent positions. This meant that staff on the floor did not see a significant change in the numbers, as they were not seeing new staff arriving.[447]

351. Dr Anwar conceded that the Inquiry found that there seemed to be disconnect between the urgency of concerns raised by staff on the ground and the response at higher levels of governance at PCH. Dr Anwar gave evidence he felt what the CAHS Executive did very poorly at the time was to communicate to staff that their concerns raised around staffing levels hadn't fallen on deaf ears and they were actively trying to mitigate the staffing challenge but the organisation's ability to mitigate was severely hindered.[448]

352. In terms of Dr Anwar's secondment to the Department of Health on 15 February 2021, Dr Anwar indicated there was relatively limited time for planning and handover, which probably made things more difficult at CAHS as everyone had to shift and everyone's portfolio changed, which led to significant instability.[449] Dr Anwar noted that the decision was made on the grounds of "the criticality of the vaccine program in terms of the health of the population," so from a community perspective it was an important step, but it had the negative effect of destabilising the CAHS Executive team.[450]

353. Dr Wood was acting in Dr Anwar's role from 15 February 2021 until his return in April 2021, and for the rest of that time he was working closely with Dr Anwar as part of the leadership team, so he was able to speak to all of the efforts made by CAHS to rectify the staffing issues arising from the pressures of increased demand in 2020 and 2021 as a consequence of the COVID-19 pandemic. The many different strategies undertaken by the CAHS Executive have been set out above and in other parts of the

[445] T 43.
[446] T 76, 91.
[447] T 648; Exhibit 3.1, p. 55 [255].
[448] T 34.
[449] T 44 – 45.
[450] T 44.

evidence, and included in a detailed report provided to the Court, but the issues continued to impact upon the staff and patients at PCH as the situation was complex and there were no easy solutions.[451]

354. After Dr Anwar's departure on secondment, members of the CAHS Executive, Nursing Services and Co-Directors met on 30 March 2021 "to decide on further strategies to address ongoing pressures in relation to staffing and capacity at PCH and in anticipation of the coming winter months."[452] This was only days before Aishwarya's presentation. At the meeting, I am advised "a decision was made to increase the nursing establishment to allow for all of the available physical multiday beds at PCH to be staffed and opened throughout the year",[453] which would allow the organisation 'flex down' staffing options, by allowing leave when demand became low, rather than using the previous strategy of bringing in casual and agency staff to 'flex up' when demand increased. This strategy included working towards opening 10 High Dependency Unit beds that had not yet been commissioned since the opening of PCH, as well as additional provision of Staff Development Nurses to train and support the new staff. Works to progress this plan began and were formally approved by the CAHS Executive about a year later, on 22 April 2022, after Dr Anwar's return.

355. In addition, the CAHS Executive has been turning its mind to the various recommendations made from the different inquiries arising out of Aishwarya's death, as set out below.

356. By the time of giving evidence on 24 August 2022, Dr Anwar had recently resigned from his position with PCH for personal reasons, so he was no longer involved in the ongoing implementation of the CAHS plans nor the recommendations from the various inquiries. However, in parting, Dr Anwar commented that it is "difficult to convey the impact that Aishwarya's death has had on every single individual in the organisation"[454] and he believes strongly that there is no one who works at PCH who has not been touched by her death and not felt heartbroken by it. Dr Anwar believes the memory of Aishwarya will have a long-lasting impact on the way that PCH works with children and families and is confident the work will continue to be progressed by Dr Wood and the rest of the CAHS Executive.[455]

357. Dr Anwar was anxious to convey how seriously CAHS has taken these events and his belief that one of the things the CAHS Executive had done poorly, up until the inquest, was to convey to the outside world how seriously they as an organisation have taken the recommendations arising out of the Root Cause Analysis and Inquiry and that changes are being driven by those recommendations. Dr Anwar reflected that his biggest regret, at a time when he had just left his role as the Chief Executive, was that "not enough had been done in reflecting back to the community all the work that has gone on since Aishwarya has died in order to close the gaps that were exposed and to provide the public with the confidence that they quite rightly expect and demand"[456] of

[451] Exhibit 3.1, pp. 68 – 69.
[452] Exhibit 3.1, p. 69, [322].
[453] Exhibit 3.1, p. 69, [322].
[454] T 48.
[455] T 49.
[456] T 50.

our only tertiary children's hospital. Dr Anwar emphasised that every single recommendation arising from the Root Cause Analysis, the Inquiry and the ANF 10-point plan has been subject to significant scrutiny within the Executive and by the Board to ensure they understood the intent of the recommendation and work towards implementing that intent.[457]

358. Dr Anwar clarified that all of the 11 recommendations from the Root Cause Analysis were accepted without modification and the 30 recommendations from the Inquiry, but there was some modification of the 10 ANF recommendations as some did not match the way WA operates, such as reference to nursing ratios rather than nursing hours.[458]

359. Dr Wood also gave evidence about the challenging time faced by CAHS and PCH leading up to these events. He had been suddenly and without warning required to act in the Chief Executive position when Dr Anwar was seconded. A meeting with ED staff had been scheduled for the following day, but this unfortunately had to be cancelled to allow Dr Wood to get across his new duties and the challenge he was about to take on. Dr Wood accepted this may have contributed to the perception by the frontline ED staff that their concerns were not being taken seriously. Dr Wood referred to the various staff forums and other changes that have since been implemented to try and improve communication from staff, through managers, to heads of department and upwards. He accepted that, having heard the evidence at the inquest from some of the staff about their ongoing dissatisfaction, (which I set out below), particularly from nurses, it appeared that it did not seem that they had successfully formed that connection with frontline staff and there was still some way to go.[459]

360. There was expert evidence about the need to create a positive practice environment for nurses and this was supported by the nursing expert witness for CAHS, Ms Susan Baker, who is the Nursing Co-Director for the Medical Division of CAHS, within which the PCH ED sits. Ms Baker emphasised the need to ensure that junior nurses are retained. If they are tired and feel unsupported in their workplace and unable to provide optimal care, the danger is that they will look elsewhere, either in terms of a new workplace or even a new profession.[460]

361. One of the ways to provide nurses with support and improved their working life it to ensure there are enough of them to manage the patient load. It was acknowledged that there had been an increase in the number of staff since these events, with nearly double the full-time equivalent staff from 68 to 124.9, with most being nurses.[461] Dr Anwar gave evidence that it had "taken an enormous effort by the organisation and … the emergency department leadership team"[462] to try to attract staff to fill those new roles and also required an input in training new staff to ensure they are suitable to fill the roles. In the meantime, there was evidence that some of the positions are often filled by nurses doing double shifts.

[457] T 50 – 51.
[458] T 69 -70.
[459] T 715 – 716.
[460] T 654.
[461] T 45 – 46.
[462] T 46.

362. Dr Wood gave evidence about the shift in staffing at PCH by CAHS from a 'flex up' model to a 'flex down' model, which was a decision made by the CAHS Executive while Dr Anwar was on secondment in March to April 2021 and Dr Wood was the A/Chief Executive. It was noted that there had been pressure on staff for some time, they had been required to do extra shifts to try to help their colleagues deal with the surges and they and their families are not immune to sickness, so this had all ensured that there were ongoing needs to increase staffing. Their evidence was that CAHS had moved to a "more robust model"[463] that would hopefully get them to the right staffing level to be able to manage surges and protect against the variability and unpredictability of presentations coming out of the pandemic. If it ends up that they have extra staff, it allows staff the opportunity to 'flex down' by taking leave or doing education, for example. It should also hopefully accommodate changes in presentations due to population growth.[464]

363. Ms Baker gave evidence that at the time of the inquest PCH had been trying to recruit more staff to fill those extra positions in various ways. Changes to the recruitment process, including centralising the process, has brought the average recruitment process duration down from an average of 123 days to 41.5 days.[465] They have successfully recruited hundreds of nurses since then and continue to recruit, as well as shifting other staff from contract work to permanency by fast-tracking the permanency process. In addition, they increased the graduate program substantially, from 50 to 100, and placed them in medical specialty departments so they could learn from senior nurses and develop some paediatric skills quickly and hopefully be ready to be recruited to the wards on graduation. Due to the influx of junior staff placing a burden on senior staff to provide education and upskilling, PCH has put in place additional education programs and increased the number of staff development nurses to provide frontline education support across the wards and ED.[466]

364. Ms Baker indicated there were still 13 FTE's not filled at the time of the inquest, but 11 more people had been recruited so she was hopeful they were getting close to filling all positions.[467] Dr Wood expressed a similar view and felt they were getting close to the new establishment figures at the time of the inquest.

PROGRESS ON RECOMMENDATIONS

365. Dr Anwar gave evidence that of the 51 recommendations from the two reports, and the ANF 10-point plan, that PCH had been addressing prior to his departure, some were technically very easy to implement, such as the purchase of a second blood gas machine. Others have taken longer to implement as they might require cultural transformation and training, which can take time if it is going to be "embedded, meaningful and sustained."[468] Dr Anwar observed that those sort of long-term changes also require genuine investment in staff and inclusion of the staff of the entire organisation. Accordingly, while Dr Anwar said that the Executive had been

[463] T 706.
[464] T 632 - 633.
[465] T 646.
[466] T 646.
[467] T 634 - 635
[468] T 36.

motivated to implement all of the recommendations, not all had been completed by the time he resigned, not from a desire to avoid or abrogate responsibility, but simply from the complexity surrounding implementing them properly.[469]

366. Dr Anwar gave evidence that he was confident that the organisation would continue to work tirelessly until every recommendation has been embedded and translated into genuine, meaningful change.[470]

367. In relation to specific changes, Dr Anwar noted that "we know that outcomes for patients who spend protracted periods of time in the emergency department are known to be poorer than people who are managed in a timely way"[471] so a primary focus of the Executive was to reduce the length of the waiting time for presentations as much as possible. One tool introduced was the emergency telehealth service, Crisis Connect, to assist children with mental health issues to receive early intervention for what are traditionally complex presentations that are unlikely to be resolved in a brief ED visit.[472]

368. In addition, efforts have been made to facilitate rapid discharge or quick and timely admissions, through the reconfiguration of wards to allow children to be admitted, reviewed frequently and rapidly and, therefore, discharged more quickly and try and maintain flow within the organisation to reduce the chance of crowding within the ED.[473]

369. Dr Anwar expressed the opinion that some of the more important changes from his perspective is the change from a previous approach of working with a smaller core permanent staff and expanding through hiring or contracting staff when needed, to increasing the permanent core staff so there is a greater capacity to meet peak demand and when demand decreases, there is an opportunity to give staff leave. Dr Anwar believes this creates "a much more sustainable and safe staffing framework."[474] In addition, the physical changes to the ED, such as the triage desk in the waiting room, and the pink Aishwarya's CARE call phones, are all important additions to improving safety in the ED, as they improve communication with families and ensure there is a more watchful eye over patients who are waiting.[475]

370. Dr Anwar emphasised that it is important to make sure that the new processes and systems in place are robust and tolerate stresses when they arrive, which he hopes is the case.[476]

371. Dr Wood also canvassed the many changes that have been implemented at PCH since 3 April 2021 and the ongoing work that is being done.[477] Some of the changes have been initiated by CAHS of its own volition, in addition to implementing the many

[469] T 36 – 37.
[470] T 37.
[471] T 39.
[472] T 37 – 38.
[473] T 39.
[474] T 44.
[475] T 44 – 45.
[476] T 27.
[477] Exhibit 3.1, pp. 74 – 75.

recommendations from the Root Cause Analysis, ANF 10-point plan and Inquiry. Dr Wood emphasised the absolute commitment of CAHS to looking for where they need to change things and continuing to improve systems, so that they can deliver the service to the community that is expected.

372. In a supplementary report, Dr Wood provided a very detailed analysis of the various recommendations and their progress.[478]

373. Some of the more significant changes relevant to this particular case I have set out in more detail below.

Triage

374. The undisputed evidence at the inquest was that Nurse Taylor formulated Aishwarya's triage score on the day by speaking to Aishwarya and her parents and looking at her to view any clinical signs as best she could. She did not touch Aishwarya at any time and did not take any vital signs.

375. Nurse Taylor gave evidence that she would have preferred to do a hands-on assessment of Aishwarya, as it is "a bit more thorough"[479] but the way the triage assessment area was physically constructed and staffed at the time made that very difficult. The desk was deep and had a Perspex screen in place, which meant that if she had chosen to try to touch Aishwarya, she would have had to leave the triage office and come outside to do so. This was said to be impractical and also raised issues of safety. Nurse Taylor indicated that if she had been able to access Aishwarya more easily she probably would have, but not to take all of her vital signs, as that was not the accepted practice in the PCH ED. Rather, it would have allowed Nurse Taylor the opportunity to feel the quality of Aishwarya's pulse, check her capillary refill time and have a close look at other features of her presentation, such as chest sounds and work of breathing.[480]

376. The Inquiry team found that the triage desk, which had been designed with staff safety in mind, was not found to be conducive to enhanced interactions with families or ease of assessment of children, particularly after the additional COVID-19 safety measures were put in place. In addition, the potential to use the new triage area to full capacity, including dedicated private assessment cubicles, proved to be dependent on having more than one nurse present, which due to staffing issues did not occur.[481]

377. Nurse Taylor gave evidence that since these events, PCH has added a clerical staff member to perform a triage support role at the triage desk, which means the triage nurse does not have to attend to general queries and allowing parents to re-enter the Department.[482] In addition, changes have been made to the triage desk and office area, although the layout is still not ideal for taking any vital signs.

---

[478] Exhibit 3.3.
[479] T 105.
[480] T 106 – 107.
[481] Exhibit 2, Tab 29, p. 30.
[482] T 104.

378. Nurse Taylor gave evidence that in an ideal world, if the triage layout permitted it, she would like to be able to add vital signs and consider the sepsis pathway if prompted. Nurse Taylor acknowledged this would likely require a second triage nurse to be allocated to the area. Nurse Taylor indicated that prior to going on leave, another desk had been sited so that a second triage nurse could be running at the same time, as well as the clerk, when it got busy but it still wasn't common practice for either triage nurse to include vital signs in the triage assessment.[483] Nurse Taylor gave evidence that when she had previously performed triage assessments in the Broome Hospital ED, they would include heart rate, temperature and respiratory rate into the triage as collateral information. To take the temperature obviously requires particular equipment to be available, which Nurse Taylor indicated is not available at the PCH ED triage area.[484]

379. The main change made to the desk was to cut out a portion of the desk, to allow the triage nurse to sit much closer to the patient and their family and allow the nurse to reach through and touch the patient through the window, if desired. Nurse Taylor indicated the change has made it much easier to do some parts of a hands-on assessment of a patient, such as checking for signs of tachycardia.[485]

380. Dr Wood was asked about the reason for the original design of the desk, and he explained at the inquest that the desk had initially been built very deep to provide some protection to the triage nurse when dealing with possible aggression from members of the public. This was before COVID created the need to put up the Perspex barrier. Plans had been initiated to change the configuration of the desk prior to April 2021, as part of other remodelling, but the plans had not gone beyond the development stage at that time.[486]

381. Evidence was also led about the electronic triage form used at that time. A printed version was available in the brief of evidence and looking at the printed page, it gave the false appearance that Nurse Taylor had done an incomplete triage assessment as she had not filled in a large amount of information. The bottom two thirds of the page were blank, other than the weight, which was apparently written in later by a student nurse when the vital signs were being taken. The only parts entered were the Presenting Problem and the Triage Nursing Assessment and the Triage Code allocated.[487] Nurse Taylor indicated that the other parts of the form are no longer used in the PCH ED in its current electronic form, but the form has not yet been updated to reflect that change.[488] Nurse Taylor agreed in questioning that the form, in its current format, is no longer "fit for purpose."[489]

382. There was no triage policy specific to PCH in place at the relevant time, although there was a general triage document setting out procedures and guidelines and triage nurses

[483] T 125 – 126, 132, 142.
[484] T 135 – 136.
[485] T 135.
[486] T 670 – 671.
[487] Exhibit 14.1.
[488] T 130.
[489] T 130.

were trained to follow the Australasian College for Emergency Medicine (ACEM) policy and guidelines. A specific triage policy was later introduced.[490] In her evidence, Nurse Taylor indicated that she did not think the new policy would have changed her assessment of Aishwarya, although she might have documented information in a different layout.[491]

383. Information was provided that the ACEM guidelines do not require that vital signs be taken at triage.[492] Dr Nair accepted in his evidence that this is the case, although he noted different places do take at least some vital signs at triage. Dr Nair commented that in his view, not taking observations at triage (in line with the ACEM guidelines) is "reasonable provided those observations can be done in a timely manner in an appropriate setting."[493] Dr Nair suggested observations should be done within a clear timeframe of 15 to 20 minutes, if not done at triage, noting that the observations will inform the initial triage assessment and make it subject to early revision if additional information suggests the triage score might require amendment.[494]

384. There was evidence provided by CAHS that there is now a clerical officer and a triage support nurse assigned to the triage area. The clerical officer is able to facilitate access for patients and answer queries, thus reducing the interruptions and disruptions to workflow for the triage nurse. The triage support nurse role has been implemented to assist with escorting Category 1, 2 and 3 patients to their destination within the ED, ensuring that the triage desk is always staffed.[495] While CAHS considered the two staffing changes to be an improvement to the system, it was submitted that these changes were not directly related to the outcome in Aishwarya's case, as she was triaged without delay.[496]

385. The other change that has been made that assists parents wishing to raise concerns is the addition of a visible workspace/desk for nurses in the waiting room, along with rostering on dedicated senior waiting room nurses to monitor patients in the waiting room, as set out below.

Waiting Room Nurses

386. Ms Lytwyniw gave evidence that it was common for parents of patients to approach the ED clerks with queries, given at that time they were the only staff generally seated at a desk in the waiting area and the desk did not have anything to identify it as the administration desk. The clerks also did not wear any kind of badge or uniform to identify their position, only ordinary plain attire, so depending upon the person, they may or may not appreciate the distinction between the health staff and the nurses and doctors.[497] Ms Lytwyniw indicated she did not have any specific training on dealing with these queries or any policy to follow, but generally it was the more experienced

---

[490] T 131, 664 – 665; Exhibit 3.1, pp. 15 - 16.
[491] T 142.
[492] Exhibit 3.1, pp. 12 - 13.
[493] T 527.
[494] T 527.
[495] T 663.
[496] Exhibit 3.1, p. 15.
[497] T 156, 161.

clerks who filled these roles and they would use their own common sense and good judgment in answering them.[498]

387. Many of the questions would be routine, such as asking for directions to the toilets or asking for a blanket or water, while others would ask about the estimated wait time and how many patients were coming through the department. Ms Lytwyniw said she might sometimes check the computer screen to see how many patients are waiting, so she could provide information that there is quite a big wait list and perhaps provide a rough estimate as to the waiting time, based upon past experience. If the parent's approach was in relation to being worried about their child's health or new symptoms they were experiencing, she said she would direct them to the waiting room nurse or go and request a nurse to come and see them if the waiting room nurse was busy.[499] Obviously, as the clerks have no medical or nursing training, their ability to identify a deteriorating patient is limited, but they did indicate that if they saw someone collapse or become obviously unwell, they would go and get a doctor or nurse without being requested.[500]

388. The events surrounding Aishwarya's death showed that there was a need for a more obvious presence of nurses in the waiting room. Therefore, capital works were undertaken within the waiting room to provide a visible workspace for dedicated, senior waiting room nurses, who were to be rostered on 24/7 so that they could be in a position to monitor patients and to be a consistent point of contact for concerned parents and carers.[501]

389. Ms Lytwyniw gave evidence the new desk has helped the clerks as there are usually two nurses sitting there, so parents can approach the nurses rather than the clerks in the first instance, or the clerks can direct parents to those nurses.[502]

390. Mr Vijayaraghavan also gave evidence that he believes the addition of the waiting room nurses, who are visible and always present in the waiting room, has been very helpful for the ward clerks as they can point parents directly to those clinical staff if any concerns are raised, whereas before it was sometimes difficult to find a nurse to speak to regarding a parent's concerns.[503]

391. Nurse Vining gave evidence "the amount of increase in nursing staff is just crazy,"[504] and still increasing, with three allocated waiting room nurses rather than one, as well as the waiting room nurse desk with two computers for them to use. She also noted the new set policy that the WRN cannot be allocated to other duties and must remain in the waiting room at all times. Nurse Vining agreed if these changes had been in place on the night of Aishwarya's death, her actions would have been dramatically different.[505]

---

[498] T 163.
[499] T 151, 166, 169.
[500] T 152 - 153.
[501] Exhibit 3.1, pp. 26 – 27.
[502] T 157.
[503] T 305.
[504] T 263.
[505] T 263.

392. Having reflected on this case and noting her sincere regret and condolences for Aishwarya's family, Nurse Vining said she has also personally made changes to her own practice. This includes getting patients to walk to the weighing chair, so that she can see them moving, which she felt was a big change to aid her assessment. Nurse Vining also indicated she now has learnt the importance of contemporaneous documentation, which can be difficult in a busy ED so she has gained the confidence to not say 'yes' to every request for assistance and to understand her limits, so that she can perform the parts of her role in a safe and timely manner.[506]

393. Nurse Vining had agreed in questioning from counsel that at the relevant time, she was required to enter data into at least five different datapoints, which was very time-consuming, especially on top of a busy workload and noting she did not have easy access to a computer.[507] Obviously the addition of a waiting room nurse desk with two computers is a step in the right direction, but the fact she had to write information down on her arm and then go back to enter it is not solved by that improvement.

394. Dr Speers agreed that the introducing of a waiting room nurse station with nurses to remain at their posts should assist with identifying future sepsis cases. This is because the nurses will have more time to do repeat sets of observations, which will help them to identify a deterioration in the patient's physical and mental state.[508]

395. I am also advised that CAHS has undertaken some building works to improve visibility for nurses within the waiting room.[509]

Aishwarya's CARE Call

396. A consistent finding throughout all of the later inquiries and expert reviews, and what is highlighted from my own review of the evidence, is that the importance of Aishwarya's parental concern was overlooked on the night, and they had very few options available to them to escalate their concerns. The Root Cause Analysis Panel found a lack of recognition of persistent and significant parental concern resulted in a delay in escalation, which may have contributed to the outcome. It was also noted there was no clear escalation pathway for parents and carers in the PCH ED and an uncoordinated staff response as well as a lack of documentation of that response, which led to a delay in the initiation of treatment.[510]

397. CAHS acknowledged there was no written guidance for how staff should respond to approaches in the ED waiting room from family regarding concerns in April 2021. Nor was there any signage or a clearly articulated pathway for parents to escalate their concerns. It was considered that a reasonable response at the time by a non-clinical staff member would have been to relay the concerns to a clinical staff member, and this was what the ward clerks did in this case. However, it was accepted by CAHS that a more formal approach was appropriate.[511]

---

[506] T 264.
[507] T 268.
[508] T 494 – 495.
[509] T 675.
[510] Exhibit 1, Tab 25, pp. 22 – 23; Exhibit 3.1, p. 25.
[511] Exhibit 3.1, p. 25.

398. Immediately following Aishwarya's death, the ED Medical and Nursing leadership team developed instructions for staff outlining the appropriate actions to take if parents or carers raised concerns about their child's condition while waiting to be seen in the waiting room. Specific instructions were formulated for clerical and clinical staff and education provided. The information is also now included in new staff orientation.[512]

399. In addition, a family escalation of care process was introduced into the PCH ED waiting area. There was already a family escalation of care process in place at PCH, known as the CARE call, which provide a 3-step process for parents to follow if they have concerns that their child's condition is deteriorating, starting with talking to a nurse or doctor, then escalating to a nurse coordinator and then the third step involves making a CARE call. This system was based on an Eastern States model. However, the CARE call was only available on the inpatient wards and in the Emergency Short Stay Unit of the ED, but not in the other parts of the ED, including the general waiting area.[513]

400. Since Aishwarya's death, this position was reviewed, and the CARE call system has been extended into all WA Health Hospital ED's and outpatient settings in a very prominent way with pink phones and signage. It is known as Aishwarya's CARE call and is designed for family members to use if they are concerned the patient's condition is deteriorating. I understand the call goes through to a senior nurse, who will usually come to the ED to speak to the parents/carer and child and help escalate their case locally, if appropriate, or else arrange escalation of care to a clinical review by another staff member.[514] Dr Anwar described the addition of the pink phones as a "really powerful transformation"[515] and it is hoped that access to these telephones empowers parents who are worried about their child and believe they are not receiving timely care.[516]

401. CNS Kennedy is one of the senior nurses at the hospital who routinely responds to care calls from the pink Aishwarya CARE call phones in the PCH ED waiting room. CNS Kennedy gave evidence that the function of the phones is to provide "an escalation pathway for parental concern related to clinical deterioration."[517] She explained that it is a three-step pathway, with the CARE call the final step. The first step is for a concerned parent or guardian to talk to the nurse allocated to the child's care. If that step does not provide a satisfactory resolution to their concern, then the parent is encouraged to speak to the shift coordinator for the department, who is identifiable by a yellow sash. If their concerns are still not resolved, then the third step is for the parents to call the number through the pink CARE call phones, which then connects them with the Clinical Nurse Specialist who is responding to the calls at that time. Those calls that come from the ED can then either lead to the patient being reviewed personally by the CNS, or it may be escalated through the ED shift coordinator, depending upon the nature of the concern. If the concern is about clinical

[512] T Exhibit 3.1, pp. 25 – 26.
[513] T 44, 47; Exhibit 3.1, p. 26.
[514] T 44 – 47; Exhibit 3.1, p. 27 and Attachments 12 and 13.
[515] T 44.
[516] T 45.
[517] T 463.

deterioration, that will likely result in the CNS attending to do a review, whereas a more general concern about wait time may be directed to the shift coordinator and the consultant of the day.[518]

402. CNS Kennedy gave evidence that in her experience, many of the calls relate to concerns about wait times, but even in those cases, she believes a senior nurse review is still helpful to put some of the concerns at ease.[519]

403. Dr Hollaway gave evidence that he has learnt over the years through his ongoing training and increasing seniority, the importance of giving weight to parental concern. Dr Hollaway commented that, "I worry when a parent worries."[520] Dr Hollaway explained that it might be in the end that the parent is worried about nothing important, but he thinks it is important to listen to them, as they have spent many hours longer with their child and know them best.[521] The introduction of Aishwarya's CARE Call is hopefully another tool for parents to convey those concerns to the right person, who will listen and take action.

404. I also note the other evidence provided about improvements in communication such as significant changes to the signage in the ED, information available on electronic screens and text messages containing relevant information to caregivers after triage.[522]

Tools for Identification of Sepsis

405. In the report prepared on behalf of CAHS and co-authored by Dr Wood, it was stated that:[523]

> *With the benefit of hindsight it may seem obvious that the assessment of Aishwarya in the waiting room revealed symptoms and signs of an underlying sepsis which was not recognised at the time. The following signs and symptoms, which are in keeping with sepsis, were present: parental concern; increased respiratory rate; cold peripheries; unexplained pain; and fever. It should be noted, however, that even in combination, these signs are still not specific for an underlying bacterial sepsis. Similar findings can also be seen with the systemic inflammatory response that might accompany a viral illness, such as viral gastroenteritis. Recognition of sepsis in children remains a significant challenge for clinicians, and this is recognised nationally and internationally. ... It is important to note, as both Dr Nair and Dr Speers have, that viral illness presentations to paediatric ED's are significantly more common than critical illness such as sepsis. They have noted that this can lead to the cognitive bias, which can contribute to a failure to recognise sepsis, particularly by less experienced clinicians.*

[518] T 463.
[519] T 464.
[520] T 339.
[521] T 342.
[522] T 716 – 717; Exhibit 3.1, pp. 70 – 71.
[523] T 673; Exhibit 3.1, p. 23, [116].

406. It is for this reason that, although it is rare, CAHS recognises that there needs to be a pathway to help prompt staff to consider sepsis at an early stage. CAHS noted that there has been, and still is, 'no standardised assessment or management of sepsis across Australian or international health facilities. This is because there is a lack of consensus on the benefits versus risks of screening, including concerns regarding the potential unintended effects of sepsis screening, such as alarm fatigue or inappropriate resource utilisation, which makes establishing a consistent approach difficult.[524]

407. Due to the difficulty in reaching an international, or even national, consensus, in 2020 senior clinical leaders from various PCH departments began to work together to create their own sepsis recognition tool, which resulted in the PARROT chart. The PARROT chart was still in the development phase when these sad events occurred and was used in parts of PCH as a pilot. More work was being done to refine the sepsis recognition tool and a 'Sepsis Recognition Escalation Pathway' has now been incorporated into the PARROT chart. The PARROT chart version 3.0, including the Sepsis Recognition Escalation Pathway, was put into practice on 28 April 2021 and I gather from the information provided for the inquest that there is now a PARROT chart version 4.0, which is the current version.[525]

408. In Aishwarya's case, the signs/symptoms of temperature > 38 degrees combined with cold peripheries, unexplained pain and family concern, would come within the Sepsis Recognition Escalation Pathway amber section, which requires the clinical response of sepsis review by the medical team within 15 minutes, notification of the most senior doctor in the ED at the time, referral to the paediatric sepsis guideline for time critical treatments and other steps that can lead to referral to the Paediatric Critical Team.[526]

409. Dr Hollaway gave evidence that with the introduction of the new PARROT chart at PCH, all staff had to do a training module on it. He noted that the use of the chart will inevitably lead to an escalation of care for many patients who do not, ultimately, have sepsis. Dr Hollaway indicated that the evidence suggests only 1 to 10% of patients will ultimately have any significant findings and most will not initially be as critically unwell as Aishwarya, so 90 to 99% of the patients escalated may end up having unnecessary investigations.[527] Dr Wood agreed that there will be 'false positives' with this screening tool, but nevertheless, the consequences of missing the diagnosis is such that it is still important to capture the other cases and then eliminate them.[528]

410. CAHS had also established a Sepsis Program to support ongoing work at CAHS in relation to improving Sepsis Recognition and Management.[529] Further information about what steps have been taken since the inquest in this regard, was forwarded to the Court recently by Dr Wood.[530] It was noted that CAHS has been implementing the Australian Commission on Safety and Quality in Health Care (ACSQHC) Sepsis

---

[524] T 677 - 678; Exhibit 3.1, p. 30, [147].
[525] Exhibit 3.1, pp. 23, 30 – 31 and Attachment 7; Exhibit 4B.
[526] T 682; Exhibit 3.1, pp. 32 – 33.
[527] T 338.
[528] T 678 - 679.
[529] T 683; Exhibit 3.1, [165] and [364]; Exhibit 9.
[530] Exhibit 9.

Clinical Care Standard, which was formally launched in June 2022 (so pre-dating this inquest but post Aishwarya's death). Its focus is aimed at recognition of sepsis and commencement of time critical management. The implementation of the new PARROT chart including the Sepsis Escalation Pathway, in concert with the revised PCH Sepsis Recognition and Management Guideline was part of that process, but information was provided that further work has led to the development of a new Sepsis Pathway document, which was due to be launched at PCH on 20 February 2023.[531]

411. Dr Wood advised that the new Sepsis Pathway document pulls together into a single document the key elements of recognition and time critical management that is to be commenced by clinicians if sepsis is suspected. The Sepsis Pathway, as well as guiding clinical care, will apparently allow better record-keeping and capturing of data related to sepsis management for both individual patient records and overall sepsis management at PCH, which is part of the ACSQHC Sepsis Clinical Care Standard. Its introduction will require appropriate education for clinical staff in the use of the new Sepsis Pathway, and steps are being taken by CAHS to ensure that training is conducted.[532]

412. It is important to note, however, that in terms of diagnosis of sepsis, Dr Hollaway expressed the opinion that while observations are important, "serial observations are even more helpful"[533] as then the doctors can see a trend. He observed that some electronic medical records will have automatic sepsis triggers as part of them. It will still mean that only between 1 to 10 per cent of those children will be likely to go through an actual septic event or bacterial illness, so it is not a more accurate predictor, but it simply ensures that the criteria to trigger clinical suspicion for the onset of sepsis will not be missed.[534]

413. Dr Hale also emphasised the importance of multiple sets of observations to assist in diagnosing sepsis, by allowing doctors to track and observe a child's progress, to see whether they respond and get better with treatment or show ongoing symptoms or signs of clinical deterioration that regard. Dr Hale agreed that it is important for ED staff to keep sepsis at the forefront of their mind, but noted that a child presenting with a high temperature and/or cool peripheries is not unusual, so the focus is on ongoing observations and monitoring.[535]

414. Dr Cross, a paediatric consultant with significant experience in treating paediatric sepsis, said in his opinion "the period of observation is critical"[536] so that they can monitor the response to the usual simple interventions.

415. Therefore, it is important along the way when using these pathways for staff to have the time to continue to monitor and observe a patient. That is where adequate staffing comes into play. There were tools in place on the relevant night, but the staff did not have the time to stop and reflect on them and make use of those tools properly.

[531] Exhibit 9.
[532] Exhibit 9.
[533] T 347.
[534] T 347.
[535] T 422 – 423.
[536] T 450.

Dedicated Supernumerary Resuscitation Team

416. There was evidence given that in August 2021 the CAHS Executive approved an increase in FTE's to support a dedicated Resuscitation Team in the ED. However, evidence was given by Ms Baker at the inquest that there was still no dedicated resuscitation team functioning at PCH as they did not have the staffing capacity to fill it. Therefore, while it had been built into the establishment, there has been no practical effect felt by the ED staff as they are still being pulled away from their allocated tasks to assist with resuscitations, which are an obvious priority. Ms Baker gave evidence that in September 2022 they were still actively recruiting and while they still had a vacancy of 15 FTE with a vacancy of 13 point of care staff, they were hopeful at that time that 11 additional nurses were about to join the staff in the following weeks and recruitment was ongoing.[537]

417. However, Ms Baker also conceded that the level of staffing was affected by the impact of COVID, which was requiring more staff to take sick leave and to put on PPE, which realistically meant they needed another layer of extra staff required on top of the new establishment number to cover sickness and COVID impacts.[538] This suggested that an operational dedicated resuscitation team was a long way away from being achieved.

418. Dr Nair has worked at the Children's Hospital in Adelaide and in Queensland, and in both those hospitals there was a dedicated resuscitation team. He felt it was beneficial as "it gives you a little bit more capacity if you've got one or two resuscitations going on" by creating a buffer for staff so that you don't have to draw too many staff away from their other jobs, which can leave gaps in the care being delivered.[539]

419. However, Dr Nair was also sympathetic to the recruiting issues still faced by CAHS. Dr Nair gave evidence of his own firsthand experience with the difficulties in maintaining appropriate staffing levels during the COVID epidemic, during his time as Head of Paediatrics at Ipswich Hospital. He described having to send 80% of his staff home due to illness and isolation requirements and then having to shut down the entire outpatient service as a result, focussing solely on the labour ward and delivering babies. If sick children came into the ED, they were stabilised and then admitted so that they could be sent elsewhere in the hospital. Dr Nair also acknowledged the difficulties recruiting new staff to fill the gaps in current times.[540]

420. The difficulty is, while there are accepted reasons for the inability to staff the resuscitation team, it means that the same problems are still facing the ED staff, who are suddenly pulled away from their duties and are unable to complete treatment plans or provide continued monitoring. However, I note that some of those issues, at least in terms of the waiting area and the difficulties it presented in Aishwarya's case, are resolved by the addition of dedicated waiting room nurses.

---

[537] T 650.
[538] T 650 – 651.
[539] T 561.
[540] T 550 – 551.

Moving Children's Care Closer to Home

421. One other aspect for change, that wasn't really canvassed in detail in oral evidence but did arise in the documentary evidence, was the proposal to access non-tertiary care for children closer to people's home, thus lessening the demand on PCH. Evidence was provided that attempts to transfer admitted patients from PCH to more appropriate, close-to-home or non-tertiary care was reported to be difficult and complex.[541]

422. Information was provided that the CAHS Board is still seeking the integration of paediatric clinical care across the WA health system to ensure comprehensive and timely care closer to home. However, this requires many changes, including funding allocations/redistributions, comprehensive outpatient services and engagement with community service providers.[542]

423. One obvious area for this to be done is in the area of mental health services, and in particular treatment of eating disorders. I am aware that a proposal to build Western Australia's first dedicated eating disorder centre as part of the Peel Health Campus has derailed and as far as I am aware, there has been no progress on building such a centre elsewhere. The Federal Government has made a funding commitment towards establishing such centres across the nation, and some States have made progress, but it appears WA is still at stage one. I do not propose to make any recommendation on this matter, given there was no specific evidence led, but I simply emphasise the evidence put before me about the unprecedented increase in eating disorder patients that was part of the pressures on the PCH ED at the relevant time, given the increase in number and the consumption of services that entails. I query why more progress is not being made to build a centre that is designed specifically for the care and treatment of these types of patients and where they can receive early intervention and prevention through specialised services. We as a State are falling way behind other States in this regard, and our children will suffer as a consequence.

STAFF RESPONSE TO CHANGES

424. Dr Hollaway gave evidence that there have been a lot of very positive changes since April 2021. He had noticed vastly increased nursing numbers and an increase in doctor numbers as well, with both junior and senior doctors having extra cover. Further, there have been changes to the electronic medical records, namely the EDIS screens, so that doctors can enter contemporaneous notes even without the presence of the paper notes. Dr Hollaway expressed the view that the most important changes, however, has been the introduction of the permanent presence of two waiting room nurses and Aishwarya's CARE Call.[543] As a result of these changes, while there are still long waits in the waiting room, Dr Hollaway's opinion was that "it feels a bit safer"[544] although the long wait times due to an increased number of patients is still concerning.[545]

[541] Exhibit 2, Tab 29, p. 31.
[542] Exhibit 2, Tab 29, Letter to Dr Russell-Weisz dated 8 November 2021.
[543] T 339 – 340.
[544] T 346.
[545] T 359.

425. Nurse Hanbury gave evidence that they have more numbers and more bodies, but at least at the time of the inquest they were still often four staff short per shift and the ED nurse staff will still be the first to be called to relieve other shifts if the wards are short, meaning they are often short staffed at those times. She noted that they do usually have three proper WRN's rostered, as required, but the WRN's are still not always able to be 24/7 in the waiting room as they are still required to float for the resuscitation team at certain intervals.[546] Therefore, Nurse Hanbury suggested that from her perspective, she had seen some change and acknowledged that effort was being made by management to improve conditions, but there was still a lot of work to be done.[547]

426. Nurse Davies, who works as a senior nurse in the Shift Coordinator role at PCH ED, advised that the ED was still exceptionally busy and while nursing numbers had increased to a theoretical 26 on an afternoon shift, from the previous 15, there was still no dedicated resuscitation team and they were often four or five staff down, meaning there will only be 19 or 20 staff on shift. This means that whenever a resuscitation occurred, nurses are taken from other duties to attend. Despite nurses repeated requests for a dedicated resuscitation team, that demand had still not been met.[548]

427. Nurse Davies also commented that many of the new nurses are either straight out of university or are junior nurses who have no experience in paediatric ED and require a lot of support, which slows down the work of the experienced paediatric nurses as they have to train them on the floor and supervise them closely. The new nurses are also only able to care for a much smaller number of patients safely, given their inexperience, which means the more experienced nurses have to take half of their load.[549]

428. Nurse Davies expressed her view that there is still "a massive disconnect between executive and staff on the floor."[550] She believes that nothing much has changed since Aishwarya's sudden and untimely death and the ED is still extremely busy, with insufficient nursing cover and when a resuscitation is required, calling nurses away from their duties, she is very concerned that another tragic death might happen again.[551] Nurse Davies emphasised the pressing need for a dedicated resuscitation team in order to ensure the safe operation of the PCH ED. If that is not possible to have a full dedicated team, Nurse Davies suggests that even having two or three extra nurses dedicated to resuscitation would be a significant improvement in safety and workload, noting that when nurses are called away to assist with resuscitation, it is urgent and they are not able to handover their existing patients before leaving.[552]

429. It was suggested to Nurse Davies in questioning that the CAHS Executive might be taking steps to address the issue of a resuscitation team that had not been disclosed to her. She agreed it was possible, but observed "we aren't made aware of anything."[553]

---

[546] T 380 – 381.
[547] T 381.
[548] T 394 - 395; Exhibit 2, Tab 38.
[549] T 395, 405; Exhibit 2, Tab 38.
[550] T 398.
[551] T 399.
[552] T 399 - 401; Exhibit 2, Tab 38 [67].
[553] T 404.

This response is really a demonstration of the disconnect between management and the staff on the floor that Nurse Davies had mentioned in her evidence, and which has been an ongoing problem for the hospital.

430. As Dr Wood acknowledged, it is concerning that these feelings are still being expressed by the staff in the ED.

COULD AISHWARYA HAVE BEEN SAVED?

431. A key question in this inquest is whether, if Aishwarya's serious condition had been identified and earlier treatment had been initiated (sometime between her arrival at 5.30 pm and the initiation of an escalation of treatment at 7.00 pm), could Aishwarya possibly have survived. Dr Speers' opinion, which was unchallenged by any other expert, was that while her chances of survival were small, he could not say that there would have been no chance that Aishwarya might have survived if antibiotics and fluid resuscitation were provided at an earlier stage. Put another way, Dr Speers "couldn't say with absolute certainty that Aishwarya would have died anyway."[554] As he put it, "it would have been a chance, but it's difficult to quantify what that chance would have been."[555]

432. Dr Speers gave evidence there were pointers that "sepsis was at play,"[556] but for a number of reasons, including the experience of the people assessing her and their availability to assess her and monitor her over a period of time, the pointers were missed. By the time her condition was identified and treatment commenced, it was clearly too late.[557]

433. On the balance of probabilities, Dr Nair considered it unlikely that the outcome would have been any different. However, like Dr Speers, Dr Nair could not say with absolute certainty that she wouldn't have survived if she had received appropriate treatment in the first hour.[558]

434. It was acknowledged that, even if Aishwarya had survived initially, a successful outcome long-term would also not have been guaranteed. The damage to her organs may have been too extreme for her to ultimately survive or she may have suffered other complications that eventually led to her death. If she did survive, she may have suffered permanent disabilities up to and including the need for amputation of extremities, and even brain damage as a result of hypoxia.[559] However, all of this is speculation and I have absolutely no doubt that Aishwarya's parents would have taken any chance for their daughter to be kept alive and given every opportunity to recover. They continued to beg the doctors on the night to keep trying to save Aishwarya, even after they were told it was too late, as their single focussed desire was for their daughter to survive these terrible events. All of their actions since that time have been

[554] T 519.
[555] T 519.
[556] T 518.
[557] T 519.
[558] T 555 - 556.
[559] T 515, 519.

steadfast in their memory of her and a need to find out why the doctors couldn't save her.

435. In conclusion, there were a number of potential opportunities for someone to intervene at an earlier time during the night, and sadly those opportunities were missed. No one can say now that an earlier intervention would definitely have saved Aishwarya, but similarly, no one can say that there is no chance she could have been saved. She was certainly very unwell when she first arrived at the hospital, but all of the evidence suggests she deteriorated over a period of time, and only really crashed after she had been taken into Pod B and shortly before she was rushed to the resuscitation bay. She was then given the sepsis bundle of antibiotics and fluid support and treated in all ways appropriately, but by then all the experts are in agreement that it was far too late.

436. I am satisfied on the evidence before me that there was a small possibility that if proper treatment had been initiated between the time between when Aishwarya first presented to the hospital and after her observations were first taken by Nurse Vining, that Aishwarya's life might have been saved. That chance, albeit statistically small, was enormously significant to Aishwarya's family.[560]

437. Dr Speers expressed the opinion that it was "impossible to say what assessments would have been done if there were more staff available. But busyness and competing demands, unfortunately, will always limit the time you have to assess people."[561] This can have an impact because assessments aren't done, and also because people do not have time to stop and think about the situation and consider alternatives, as this takes time.[562] In the case of Nurse Vining's plan to give Aishwarya a trial of fluids on the assumption she had viral gastroenteritis, Dr Speers expressed the opinion that it would not have improved things, which would have been a trigger for Nurse Vining to consider that it was something other than simple viral gastroenteritis that was causing Aishwarya to be unwell.[563] However, this would have required Nurse Vining to have the time to start the trial and then come back and do another set of observations to see if anything had changed with a bit of fluid.

438. In Dr Speers' opinion, the way to try to ensure similar cases to Aishwarya's are recognised at an early stage is through a holistic approach, which includes training, proper pathways and systems and staffing.[564]

439. Professor Della referred to research conducted in Queensland that demonstrated that a heavy patient load combined with low staffing can lead to "a failure to rescue a patient."[565] Professor Della described the process as:[566]

> *where you don't have enough nurses and therefore … you start to miss care, you start to delay treatment, you start to see poor communication*

---

[560] Submissions on behalf of Aishwarya's Family filed 18 October 2022.
[561] T 493.
[562] T 493.
[563] T 493.
[564] T 514.
[565] T 617; Exhibit 2, Tab 45, p. 6.
[566] T 617.

> *practices, you start to have shorter times. This all adds up to a failure to rescue. And a failure to rescue, of course, is a failure to rescue a patient and that leads to patient's increased mortality and increased morbidity. And so patient's deaths do occur.*

440. The research also identified that the failure to rescue is often in relation to specific complications, one of them being sepsis.[567]

441. That seems to me, in many ways, to be an apt description of what happened here. Aishwarya's parents brought their daughter in to hospital because they knew she needed help, but due to the pressures on them, the medical and nursing staff missed the signs that she was critically ill from sepsis and failed to rescue her. It really is as simple, and as tragic, as that.

442. Importantly, at the present time, doctors and researchers still do not have a clear understanding of why some patients develop invasive Group A Streptococcal infections and others do not. There is ongoing research in the field to try and further elucidate what makes some patients especially susceptible.[568] So far, there is nothing that has been found to explain why Aishwarya was one of the very unfortunate few. The catastrophic consequences of failing to miss this condition and initiating early treatment means that there needs to be a high clinical index of suspicion for sepsis, and extrapolating from there invasive Group A Streptococcal, even if it means catching children who do not ultimately have the bacteria.[569]

443. This is particularly important given the increasing incidence of invasive Group A Streptococcal infections. Dr Nair referred to a recent article that supported the disease becoming a national notifiable condition Australia-wide, which I understand has since occurred.[570] Dr Nair noted that the study established that the incident rate per year annually in children was slightly higher than the annual incident rate for meningococcus.[571] A lot of research has gone into meningococcus as it has been considered a national health issue, with the result that there are now vaccines available for a number of types of meningococcus, but there is currently no vaccine for invasive Group A Streptococcal infection. Dr Nair noted that the records show that every few years a child dies in Australia from step toxic shock, and this needs to focus everyone's attention on the need to be looking for this disease, because although it is rare its incidence is increasing, and it can be fatal. Dr Nair emphasised the need for not only health staff awareness, but also general awareness in the community, so that everyone is thinking of the possibility.[572]

444. With that in mind, I note that Aishwarya's tragic sudden death has certainly focussed the mind of the Western Australian community about this terrible disease, and there have been a number of recent media articles alerting the wider Australian community

[567] T 618.
[568] Exhibit 2, Tab 27.
[569] T 489, 541 - 544.
[570] Group A streptococcal disease – invasive (iGAS) | Australian Government Department of Health and Aged Care.
[571] T 542.
[572] T 549 - 550.

to health warnings about invasive strep A infections as the trend of an increase in cases appears to be continuing into 2023. The reasons for the increase are unclear, and may be related to easing of COVID-19 pandemic restrictions or it is possible there is a new strain of strep A emerging. Work is continuing towards creating a vaccine, but it is not ready yet so in the meantime, parents and healthcare providers need to be reminded to keep it in the back of their minds when a child is unwell and act expeditiously to seek treatment. The onus is then on clinicians to keep the possibility at the forefront of their minds.[573]

COMMENTS ABOUT THE PUBLIC HEALTH SYSTEM

445. I have made a number of comments about missed opportunities throughout this finding. They largely relate to missed opportunities to stop and consider Aishwarya's presenting symptoms more closely and to listen to the repeated concerns being raised by her parents.

446. The most significant opportunity to identify that Aishwarya required closer monitoring and assessment was after Nurse Vining took her observations at approximately 5.50 pm to 6.00 pm. The observations based on prompts from the PARROT chart, produced an early warning score of 2, meaning that a senior nurse review, increased frequency of observations and consideration of a medical review were required. However, Nurse Vining gave evidence that she didn't complete the PARROT chart until 6.43 pm, and she then handed over to Nurse Wills without taking those escalating steps, although she did communicate her plan for fluids and ibuprofen.

447. It's clear that Nurse Vining did not follow the PARROT chart prompt, and she accepted that, although she also gave evidence her training in this new chart had been limited. She also gave evidence that she believed if she had not been pulled away to other duties and had been able to stay in the waiting room and monitor Aishwarya, she believed she would have been able to recognise her deterioration and take appropriate action. As it was, even if she had taken immediate action after finally being able to complete the PARROT chart, the expert evidence indicates it was very unlikely to have made any difference to the outcome, as by 7.00 pm Aishwarya had reached a critical stage in her illness.

448. A compelling reason given for each staff member not appreciating or acting on those signs or concerns was the busyness of the ED and the lack of staff to manage the number of patients presenting, particularly when nursing staff were called away to assist with resuscitations.

449. It is important, then, to note the evidence of the email sent by a PCH ED nurse to Mr Olson on 9 March 2021 raising their grave safety concerns and their anxiety that they could not deliver adequate care to all patients. The nurse referred to cancelled meetings with Dr Anwar and the Executive team, where the nursing staff had hoped to

---

[573] https://thewest.com.au/news/health/strep-a-steep-rise-in-cases-of-deadly-throat-infection-prompts-urgent-warning-from-experts-c-9607222; Health authorities warn of a jump in invasive strep A infections among children - ABC News'; https://www.abc.net.au/news/2023-01-17/group-a-streptococcal-explainer-cases-in-australia/101854070.

escalate their concerns. The nurse also referred to the problem of nurses being pulled away to assist with a resuscitation which could leave as few as two nurses to care for the rest of the department.

450. Mr Olson arranged a meeting on 29 March 2021 and said that earlier on the day of the meeting, he spoke with the then Health Minister and informed him of the concerns raised about the PCH ED and the fact he was having a meeting with the nurses that day.[574]

451. I accept that the results of that meeting had not then been formulated and put to the CAHS Executive or the Minister, but the evidence at this inquest was that the CAHS Executive were aware of the pressures on the ED due to the number of presentations and the staffing challenges, and they had been taking steps to fix them but had been stymied by the lack of staff available. It seems the then relevant Minister had also been informed in a general sense.

452. It is deeply concerning to then see these events play out only a few days later, exactly as the nurse had feared. Nurses and doctors are left with little choice but to work within the constraints of the working environment as it presents itself to them, while raising their concerns, as they did. When they make mistakes or miss warning signs, it is important to consider their conduct in the context in which it occurs. The background points to systemic issues surrounding the resourcing of the ED, rather than the behaviour of individuals in this case.

453. Therefore, while there were acknowledged individual failings on the night by staff to do more, or to follow procedure, I am sympathetic to the ongoing pressures they faced. The alarm that patient safety would be compromised had been sounded and the staff were left to carry on as best they could until some help arrived. In those circumstances, while I have no doubt that each of these staff members has reflected upon their conduct and wishes they had made different choices on the night, I do not make any individual adverse comment against any of them. I note that all investigations by Ahpra into these practitioners has ended and there is no need to make any kind of referral, even if I was minded to do so.

RECOMMENDATIONS

454. At the conclusion of the inquest, counsel for the various parties made submissions orally and in writing. I note that only one of the parties submitted to me that I should made any particular recommendation, with others noting that a number of important changes, such as increase to nursing and medical staffing at PCH and formal escalation pathways, have already been made.

455. Ms Burke, who appeared for Nurses Taylor, Vining, Wills, Hanbury and Davies, was the only counsel who submitted specific recommendations for me to consider. Those were:[575]

[574] Exhibit 2, Tab 39 [33].
[575] Submissions on behalf of Nurses Taylor; Vining; Wills; Hanbury and Davies filed 30 September 2022.

- CAHS immediately implement and staff a supernumerary resuscitation team in the ED at PCH;
- CAHS immediately implement safe staffing ratios in the ED at PCH as apply in the Victorian equivalent paediatric ED, honouring the recommendation of the Independent Inquiry that the ANF 10-point plan be given the highest priority; and
- That consideration be given to the introduction of ‘safe harbour’ provisions, to protect nurses from Ahpra investigation and prosecution when an adverse event occurs in the context of the nurse doing their work in impossible or suboptimal workload and patient safety circumstances.

456. The first two matters were discussed at length during the inquest hearing. I was not given a great deal of information about the third matter. I was advised by Mr Olson that the ANF is developing a campaign for the introduction of ‘safe harbour’ legislation for nurses in WA, which is apparently in place in other countries. The legislation would specifically provide legislated relief from regulatory action by Ahpra or the Nursing and Midwifery Board in circumstances where nurses have flagged patently inadequate staffing levels to their senior management, and no immediate increase in staffing is provided.[576]

Nurse-to-Patient Ratio

457. Currently in the WA public hospital system, the nursing workforce is determined using the ‘Nursing Hours per Patient Day’ (NHpPD) model. I note that in Emergency Departments, including at PCH, a slightly different model is in use, referred to as the ‘Nursing Hours per Patient Presentation’ (NHpPP), which has been adapted from the NHpPD model used on the wards. The NHpPP focusses on the presentation, including the length of time the child is in the ED, rather than the number of admitted patients.[577] The NHpPD is currently part of the ANF enterprise bargaining agreement for public hospital nurses and midwives in WA, although the ANF is seeking to change that in the new enterprise bargaining agreement to the Nurse/Midwife-to-Patient Ratio method.

458. Ms Baker gave evidence that she thinks that whether there are nursing ratios or nursing hours, in practice on the frontline there is very little difference between the two because of the dynamic changing nature of the ED, which means there is no perfect model.[578]

459. A lot of the criticism of the NHpPD model is that it is based on retrospective data, which was acknowledged by Ms Baker in her evidence. She agreed that when there are unexpected peaks in activity, such as those generated by the COVID epidemic, there can be a mismatch in the modelling provided by the NHpPD. This occurred between March and June 2020, where staffing levels were higher than required, then

[576] Exhibit 2, Tab 39 [48].
[577] T 627, 632; Exhibit 3.1, p. 44.
[578] T 628, 632.

the reverse happened from October 2020 to January 2021, and again in March 2021, when the staffing levels were less than was required. Ms Baker's statistics suggested it righted itself again in April 2021, after they added additional staff and demand decreased again. Ms Baker indicated that at the time of the inquest, there had been another surge, which indicated presentations had not settled into traditional patterns.[579]

460. Ms Baker's evidence was that PCH had accepted the model they have been using has not adequately coped with the unprecedented demand and surges in the ED with limited ability to bring in more staff, so they have moved to a 'flex down' model rather than a 'flex up' model, to try to adequately staff to accommodate the surges. This would suggest the NHpPP model wasn't working.[580]

461. In his evidence at the inquest, Mr Olson said he believed nurse to patient ratios are vastly superior to nursing hours per patient per day as the latter is retrospective and is a very opaque and complicated formula and he believes the data gets corrupted so it cannot be relied upon. Mr Olson suggested that you can hide the deficiencies in nursing hours per patient per day over a period of time. He also maintains that the model makes it easy to hide nurses who aren't caring directly for patients.[581] In contrast, Mr Olson suggested that the nurse to patient ratios are transparent, easy to understand and apply and you "can't hide the deficiencies."[582] Mr Olson explained in his supplementary statement that he believes a fixed nurse-to-patient model is optimal as "it is easy for nurses and midwives to know what that ratio is and it is obvious to all where deficits are occurring on a shift by shift basis. It is also easier to ensure staffing levels are being maintained at safe levels …. on a shift-by-shift basis, and not retrospectively."[583] Mr Olson also suggested the "government gets better value for its money because it can actually see where it's going."[584]

462. Mr Olson, provided information about the use of the nurse-to-patient ratio in most Australian states, with only the states of Tasmania and Western Australia and the two territories still using a formula based staffing model, although apparently the ACT was due to move to a ratio based model at the start of this year, and the Northern Territory is moving to introduce such a model.[585]

463. Professor Phillip Della has had a distinguished career in nursing spanning over 40 years, with extensive experience in clinical nurse management. Professor Della has also been involved in significant research into patient safety and quality, especially in clinical communication and recognition of patient clinical deterioration. Professor Della was the Professor of Nursing and Head of School at the Curtin University School of Nursing, Midwifery and Paramedicine for many years and is a member of a number of Professional and Governance Boards. Professor Della was appointed to undertake an independent review of the NHpPD workload management model currently in place across the WA public hospital system by the then Minister for

[579] T 629 – 632; Exhibit 3.1, p. 45.
[580] T 633.
[581] T 576 - 577.
[582] T 576.
[583] Exhibit 2, Tab 39, Attachment 3 [24].
[584] T 578.
[585] Exhibit 2, Tab 39, Attachment 3.

Health (WA) in December 2020 (the Review). Professor Della had completed the Review and provided a report to the Director General of Health at the time of giving evidence at the inquest. The contents of the report had not been made public, so Professor Della could not discuss the actual report, although he did provide some information about the outcome of his Review and the report was later provided to the Court.[586]

464. Professor Della had also provided a report to the ANF on matters relevant to this inquest in particular, and provided his expert opinion on staffing levels, nursing models and what makes a safe work environment for nurses.[587]

465. Professor Della explained that the debate in Western Australia is between the NHpPD model, which looks at historical data and builds up the minimum staffing level based on retrospective data based using bed occupancy, versus the nurse-to-patient ratio model. In conducting the Review, Professor Della obtained information from some 1,562 individuals on the current NHpPD model and the relationship to staffing levels, staff wellbeing and patient safety and quality. "The overall findings of the Review from the perspective of the majority of nurses and midwives who provide direct care is that the staffing levels are too low to provide safe and quality patient care. They reported that not all the required clinical care could be achieved with the current staffing levels and expressed work stress, fatigue and burnout."[588] Professor Della observed that the traditional NHpPD approach "does not reflect the actual care time required"[589] as it focusses on direct clinical care and does not take into account indirect care, such as clinical documentation, ordering investigations, locating equipment and escorting patients off the ward, all of which takes time.[590]

466. Professor Della described the NHpPD as a "crude tool of working out a number,"[591] and if it is used, there needs to be an ability to increase staffing if the area needs it. Professor Della noted that there is a similar NHpPD model used in Ireland, but he described it as a more comprehensive model that allows for increasing complexity of patients and the geographical layout of the wards. Therefore, Professor Della observed that the model is more accepted by the nurses in Ireland.[592] In contrast, it is quite clear that it is not well accepted by nurses in Australia and there is a strong preference for nurse-to-patient ratios over the Australian NHpPD approach.

467. Professor Della described the nurse-to-patient ratio model as a more mature model, that has flexibilities built in to the system to allow for the different complexities of care. Unlike the NHpPD model, the patient ratio model can adjust more quickly to meet patient care demand, such as the need for a one-to-one nursing special.[593]

468. Professor Della explained that the nurse-to-patient ratio model was first adopted in California in 2004 and a ratio was set of one nurse to four patients in an emergency

[586] T 604; Exhibit 8.
[587] Exhibit 2, Tab 45.
[588] Exhibit 2, Tab 45, p. 4.
[589] Exhibit 2, Tab 45, p. 4.
[590] T 606 - 607.
[591] T 607.
[592] T 607, 616.
[593] T 608.

department. In Australia, Victoria was the first jurisdiction to adopt a patient ratio model, followed by Queensland. It has now also been implemented in the ACT and is currently being implemented in South Australia. The ratio is generally one nurse to four patients in the wards, and one nurse to three patients in an emergency department.[594] At the time of the inquest, the NSW Nurses and Midwives Union had a current industrial campaign on foot to also set a ratio of one nurse to three patios in NSW emergency departments. In Western Australia, I understand the ANF has also commenced action in the face of ongoing negotiations with the Western Australian government, which are not yet finally resolved, although I understand the WA Government has recently indicated a willingness to commit to introducing nurse/midwife to patient ratios via a phased approach over two years as part of the negotiations.[595]

469. Professor Della supports the introduction of the patient ratio model in Western Australia in a manner similar to the Victorian model, which is the longest established model of nurse-to-patient ratio staffing in Australia. In a paediatric area, that ratio is one nurse to three patients plus a shift coordinator plus a triage nurse in the morning. In the afternoon, it increases to two triage nurses as there is usually an increase in presentations at this time, then it is reduced again to one triage nurse in the evening. Professor Della also indicated it is important within that model to have the right skill mix, in terms of whether they are registered nurses or clinical nurses for example, and/or whether they have paediatric emergency qualifications. He commented that [a]ll of that builds in to patient outcomes."[596]

470. Professor Della noted that from his own conversations with junior nurses who are graduates through the alumni at Curtin University, there is a real issue for young graduate nurses in these settings, as "they don't feel supported in the clinical area. They know the senior nurses are stressed, fatigued, overworked. The staff development nurses are often taken away or doing corporate orientation so there's no one to support them."[597] This obviously factors in to their training and ability to "work a shift, let alone manage a complex patient area."[598] The lack of opportunity to seek senior clinical input runs the risk that they will simply choose not to ask for help and/or make a clinical error because they haven't had the ability to ask questions and learn.[599] It was noted that preceptoring, where a student nurse follows a nurse to learn on the job, is also an important part of learning, but this also places a burden on the more senior nurses as there is a time factor involved when they have to explain everything instead of just doing it."[600] All of this takes its toll on both the more junior and the more senior nurses.

471. In his experience, Professor Della believes "every nurse wants to go to work to give good, safe, and quality care."[601] When nurses begin to feel that they can't deliver the safety and quality level that they expect to deliver and the work environment becomes

[594] T 607; Exhibit 2, Tab 45.
[595] https://www.wa.gov.au/system/files/2022-11/2022-11-15-offer-replacement-anf-agreement.pdf.
[596] T 609.
[597] T 610.
[598] T 610.
[599] T 610.
[600] T 611.
[601] T 620.

unsafe, they will leave the organisation and look for work elsewhere.[602] In the past that might mean in another hospital, but what seems to have occurred during the COVID pandemic is that they chose other nursing jobs that had better hours and less demands, such as in the vaccination clinics, or simply choosing to retire.[603] That was the evidence of Professor Della and Mr Olson, explaining to some degree why staff couldn't be replaced and the casual pool disappeared. Professor Della commented that "we've really got to concentrate on retaining our nurses because the world is short of nurses."[604] Professor Della expressed the opinion that we need to create a "positive practice environment" if we want to retain nurses, "where the voices of nurses are heard, that there is leadership …, that they are able to practise to the full scope of their practice, that they feel supported, and that there is a program of professional development."[605]

472. Professor Della also described the casual nursing pool as vital in this regard and commented that you "need to keep them, look after them, and be very respectful and manage them. Because they get you out of a lot of problems."[606] Those problems were seen fully in the WA health system after the casual nursing pool was allowed to disappear. Without the flexibility to call on them, you are left with gaps that can't be filled, and the full-time staff have to stretch themselves to try to cover what they can. They then become burnt out.

473. Professor Della was asked about evidence from nurses on the night of Aishwarya's death that at least one of them had a patient ratio of one nurse to nine patients at times that evening. Professor Della expressed the opinion that with this ratio it "would be impossible to provide care,"[607] which means the nurse would have to start to look at rationing care, which would mean missing care such as observations, and communication with parents and patients "would become very closed."[608] Professor Della commented that in those circumstances, the problem is that from a nurse's perspective, "you're not allowing the patient or the family to express their concerns because you're time poor."[609] That is consistent with the description of what occurred on the night. Aishwarya's parents struggled to communicate their concerns to the staff because it seems everyone was too busy to stop and listen closely to them.

474. Professor Della expanded on this concept of closed communication, explaining that from his extensive research on the topic, it is clear that the communication from the nurse becomes short and sharp because they want a response back they can document quickly and move on. He acknowledged this can come across as brisk, rude and abrupt at times, and from talking to the consumers/patients in his research, their main complaint was that the nurse didn't allow them to have time to express the information that they wanted to share, noting that they might not have the health literacy to describe such things easily.[610]

---

[602] T 618.
[603] T 623.
[604] T 622.
[605] T 624.
[606] T 615.
[607] T 608.
[608] T 609.
[609] T 609.
[610] T 619.

475. The answer then, becomes time, so that the nurses have time to speak to patients and their caregivers properly and to think about what needs to be done, document it and put it into execution.

476. I am persuaded by the evidence before me, in particular from Professor Della, that the ANF's campaign for the introduction of legislated nurse-to-patient ratios in Western Australia, with the slogan "No More Than Four," is appropriate and reasonable and supported by what has been implemented in other Australian states. I understand the WA Government has agreed to its implementation through what is called the WA Ratio Model, which will replace the NHpPD (and hence, I assume, the NHpPP for the ED), although there appears to be a dispute about the time that will be taken to implement it and it seems nothing will occur to progress this until the industrial agreement is registered.

477. In the meantime, there is the real risk that patient safety will be put at risk if the staffing levels are not adequate. In support of that statement, I refer to the evidence of Professor Della, who identified the specific aspects of care affected by heavy patient loads and low staffing as including:[611]

- Missed care, care left undone, omitted care or rationed care
- Delay in clinical observations
- Shorter communication with patients and families
- Decreased clinical communication with other health professionals
- Delayed commencement of clinical treatments
- Reduced clinical documentation
- Shorter time spent with individual patients

All of these factors combine to reduce safety and the quality of clinical care, and the results can be seen in this tragic case.

478. I note that the Department of Health's own Independent Review conducted by Professor Della supports replacing the NHpPD model with a new model. Professor Della identified that the current NHpPD is not achieving its intent and "has resulted in increased workload stress, low staff morale and decreased staff satisfaction."[612] In an Addendum to the Final Report, Professor Della provided a recommended way forward to implement a safe staffing framework to replace the NHpPD, with a plan to adopt a phased approach by initially comparing the Victorian Nurse to Patient ratios against the current NHpPD staff levels and implementing the level that has a higher number of nurses/midwives per patient, then moving to a time-limited Taskforce to establish exactly what the long term Safe Staffing Framework will be and implementing it.[613]

479. While Professor Della's evidence was more broadly focussed on the whole of health, rather than just the ED, there was evidence before me that there needs to be capacity

[611] Exhibit 2, Tab 45, p. 7.
[612] Exhibit 8, Final Report Covering letter to Dr Russell-Weisz dated 20 August 2022, p. 2.
[613] Exhibit 8, Addendum, Safe Staffing Framework.

throughout the organisation in order to take the pressure off the ED when there is increased demand.[614]

480. While I acknowledge that the negotiations are obviously progressing between the ANF and the State Government, I consider it appropriate to add my own recommendation to the matter, as it clearly falls within the scope of this inquest, given the evidence before me of what occurs when the current system fails.

Recommendation 1

I recommend that the Department of Health/CAHS commit to early implementation of nurse/midwife-to-patient ratios in replacement of the current NHpPD model in Western Australian public hospitals, as advocated for by the ANF. Particular focus should be given to ensuring a minimum ratio is put in place in emergency departments as a matter of priority, given the known risks to patient safety from missed care in this setting. This should be actioned without waiting for the Taskforce to complete its work or for any agreement with the ANF to be registered. Patient safety should not wait for the outcome of such negotiations when the Department of Health's own Independent Inquiry supports such a change. The standard can be set by reference to what is currently in place in Victoria, as suggested by Professor Della in his Addendum to his Final Report.

Supernumerary Resuscitation Team

481. This issue was canvassed at length at the inquest and I understand that CAHS has made a commitment to adding a supernumerary resuscitation team to the staffing establishment in the PCH ED, but at least at the time of t he inquest, those positions had not been filled. It seems relatively obvious, in those circumstances, to make a recommendation that CAHS commit to filling those positions as a priority.

Recommendation 2

I recommend that CAHS prioritise the implementation and staffing of a supernumerary resuscitation team in the ED at PCH.

[614] T 634.

Safe Harbour Legislation

482. As noted above, I did not receive detailed evidence about the issue of safe harbour legislation for nurses in WA. Ms Burke provided information in the submissions filed on behalf of her clients that the 'safe harbour' provisions have specifically been legislated in Texas in the United States of America. The provisions are apparently designed to allow nurses who are overwhelmed by workload and concerned about patient safety to call 'safe harbour,' which presents an immediate alert to the hospital and also triggers a waiver from investigation or prosecution by Ahpra or the Nursing and Midwifery Board. Nurses can then continue to care for patients with the reassurance that if an incident occurs, they will be protected from referral to a regulatory authority provided their care was reasonable in the circumstances.

483. I understand the intention is to ensure that nurses are not left in the invidious position of having to choose to either work in circumstances where it is known that due to systemic issues patient safety is at risk and then run the concomitant risk that an adverse event occurs and they are blamed, or to choose not to work and then patients and their colleagues are disadvantaged.

484. I am urged by the ANF to recommend that consideration be given to introducing such provisions, so it is not really necessary for me to have more detail at this stage, as that could be done in the consideration phase by people better situated to consider similar legislation in other jurisdictions and the practicalities of adopting something similar in this State. Accordingly, I consider it appropriate to make the recommendation, as requested.

<u>Recommendation 3</u>

I recommend that the WA Government consider the introduction of 'safe harbour' provisions to protect nurses from Ahpra investigation and prosecution when an adverse event occurs in the context of the nurse doing their work in circumstances where known risks in the workplace have been identified and not rectified by the employer.

Clinical Documentation Burden

485. A key feature of the evidence at this inquest was the issue of documentation, and in particular Nurse Vining's evidence in that regard. Nurse Vining gave evidence that she had written the observations she took from Aishwarya just before 6.00 pm on her arm as the hard copy of the file had not been created. She then had to go a computer and enter into the system, as in any event, the bulk of PCH's medical records system is electronic. The next step would have been to also enter that information into the PARROT chart, which based on the expert evidence, ought to have prompted her to at least consider sepsis and seek a senior nursing review. However, she only completed

the chart shortly before handing over care to Nurse Wills, approximately an hour later, so that earlier opportunity to identify sepsis was missed.

486. Professor Della observed that the need to enter clinical information in various locations is referred to as "clinical documentation burden"[615] and it is a recognised problem in nursing and adds to the time, frustration and level of stress of nurses. It is Professor Della's belief that there should be, at the point of care where the nurse is taking the observations, an ability to enter and upload that information into one source of documentation. Professor Della indicated that there are systems already in existence that allow the observations to be directly entered and uploaded to the chart, such as in Singapore where he has seen them firsthand in operation and with Silver Chain nurses doing home visits in Western Australia, but they are not currently in use in hospital emergency departments in Western Australia. Professor Della noted that at Curtin University, the nurses are taught on iPads in their clinical simulation scenarios and he understands in Singapore they will be moving to replace their current 'computers on wheels' to something akin to an iPad, so he believes the technology and practical ability to use it is likely to be already there.[616] Professor Della also noted that some of the current systems available also have red flags built into them for certain observations, which could have been useful in Aishwarya's case.

487. In terms of costs of implementing such a system, Professor Dell acknowledged it would require an investment in both technology and training, but he supports such an investment being made, given the benefits to nurses and their patients.[617]

488. Evidence was provided that PCH was initially designed as a paperless hospital, with a fully integrated electronic record, but for some reason that did not occur. Dr Wood conceded that the difficulties with the documentation is a key concern for a lot of clinicians,[618] and I note that Dr Hollaway, as a current Consultant in the ED, expressed his support for the introduction of some kind of device that would allow contemporaneous recording of data in the ED.[619] Dr Wood said the issue of an electronic integrated medical record gets raised all the time as a suggestion to improve efficiency and, most importantly, patient safety. Dr Wood advised the implementation of such a change is part of a wider WA Department of Health strategy. While waiting for that to occur, CAHS is considering as part of its health strategy taking its own steps to implement a digital record similar to what is in place at Fiona Stanley Hospital, but it seems it is some way off yet.[620]

489. I required more information on this matter, which was in the remit of the Department of Health. As the Department of Health was not a party to the inquest, counsel from the SSO appearing for CAHS, Ms Thatcher SC, assisted by referring the request on to the Department of Health. After receiving the relayed request, the Director General of

[615] T 620.
[616] T 621.
[617] T 622.
[618] T 721.
[619] T 323,
[620] T 721 – 722.

Health, Dr Russell-Weisz, wrote to me on 14 October 2022 in response to my request.[621]

490. Dr Russell-Weisz advised that currently the majority (about 80%) of WA public hospital use paper medical records when providing care to patients. The Department of Health is committed to transitioning that paper based system to a state-wide Electronic Medical Record (EMR) system that will support clinical decision making and improve health outcomes for patients. Planning and delivery of the EMR is the keystone of the WA Health Digital Strategy 2020-2030. However, Dr Russell-Weisz advised that implementing an EMR system is a vastly complex and costly undertaking, which will involve a decade-long program and large-scale investment by the State Government.[622]

491. I was advised that some initial progress has been made to secure the forward commitment from the State Government, which it is estimated will be in the vicinity of $1.2 billion over the 10-year time period. The EMR program includes a 'staged approach'. This is because of the existing digital inequity across WA Health and the substantial technological infrastructure upgrade required to support EMR adoption in the hospitals. Dr Russell-Weisz advised that even contemporary facilities like Fiona Stanley Hospital and PCH will require some infrastructure investment, and older sites will obviously require much more.[623]

492. Stage 1 primarily focuses upon transitioning all hospitals off paper records and onto a digital clinical record system. The digital clinical record system was initially implemented at Fiona Stanley Hospital and subsequently rolled out to Fremantle Hospital and two WA Country Health Services. It seems surprising that despite PCH being a very new hospital, it wasn't rolled out there in the initial phase. However, it is apparently intended that it will be implemented at PCH soon, with the target to go-live currently indicated as June 2023. Other sites will be implemented at that time and later through 2023-24, pending funding.[624]

493. Stage 2 will then focus on implementing all the core features of a modern EMR. The EMR Program has commenced work on the Stage 2 Business Case to secure the additional funding required for the state-wide EMR, with the business case reportedly due for completion by December 2023, with the first site implementation targeted for 2027.[625]

494. It is reassuring to know that the Department of Health is already actively working towards the implementation of an EMR within our hospitals, and that PCH appears to be towards the front of the queue in terms of at least moving to the digital record system. I note that Dr Russell-Weisz indicated that funding is still an issue for both stages of the project, so I will simply make a recommendation to encourage the State Government to make a strong financial commitment to the project.

---

[621] Letter to DSC from Dr Russell-Weisz dated 14 October 2022.
[622] Letter to DSC from Dr Russell-Weisz dated 14 October 2022.
[623] Letter to DSC from Dr Russell-Weisz dated 14 October 2022.
[624] Letter to DSC from Dr Russell-Weisz dated 14 October 2022.
[625] Letter to DSC from Dr Russell-Weisz dated 14 October 2022.

Recommendation 4

I recommend that the State Government prioritise funding the Department of Health's EMR Program to ensure that as soon as practicable, all public hospitals in WA, and in particular PCH, have access to digital tools that make it easier for all staff to record information, access medical records and be supported in their clinical assessments. This will significantly enhance patient safety in our public hospitals.

Taking observations at Triage

495. As I have set out above, there was evidence that it was not a practice at the PCH ED for a triage nurse to take any observations, including temperature, at the time of these events. It is also not required by the ACEM guidelines, although the guidelines obviously do not preclude it being done.

496. Ms Baker, on behalf of CAHS, gave evidence that as part of the Root Cause Analysis recommendations, a senior nurse had undertaken a literature review to look at the different models of triage across the world. The review found some hospitals do take vital signs at triage and some do not. Some take temperatures at least, and some do not. The literature review apparently suggested that there was no strong evidence that taking one or more vital signs at triage improved clinical outcomes. However, Ms Baker also gave evidence that she had been advised by the clinical nurse manager of the PCH ED that nevertheless, now that there had been a change to the screen at the PCH triage desk that allows contact with a presenting child, the triage nurse is more likely to undertake some vital sign assessment, although it is dependent upon the clinical judgment of the nurse as to whether it is appropriate.[626]

497. There did not appear to be a great deal of support from the nurses and doctors working at PCH for more to be done at triage, although I do note Nurse Taylor, who was the triage nurse, was the most supportive of the witnesses called at this inquest in regard to such a change. Nurse Taylor gave evidence that if she had the time, equipment and space to do so she would take some observations in appropriate cases.

498. Dr Nair commented that in his view, not taking observations at triage (in line with the ACEM guidelines) is "reasonable provided those observations can be done in a timely manner in an appropriate setting."[627] Dr Nair suggested observations should be done within a clear timeframe of 15 to 20 minutes, if not done at triage, noting that the observations will inform the initial triage assessment and make it subject to early revision if additional information suggests the triage score might require amendment.[628]

[626] T 637 – 638.
[627] T 527.
[628] T 527.

499. I accept Dr Nair's comments are the most reasonable compromise, if taking observations at triage isn't practical, and accepting that in some cases (such as a child with a sporting injury) it isn't necessary.

500. In my view, if we are focussing on ensuring that children with sepsis aren't missed, it is important for some priority to be given to taking a first set of observations of children. I have formed that view after hearing the evidence of a number of the PCH doctors who emphasised the importance of repeat sets of observations in such cases. Dr Speers suggested that one of the benefits of the introduction of dedicated waiting room nurses will be that they will have more time to do repeat sets of observations, which will help them to identify a deterioration in the patient's physical and mental state.[629] It is for that reason that I make a recommendation for consideration of a policy being established for taking a first set of observations in suspected gastrointestinal cases, either at triage or within 30 minutes of presentation, noting that the sepsis guidelines emphasise the importance of providing treatment within one hour.

Recommendation 5

I recommend that CAHS give consideration to implementing a new procedure for observations to be taken at triage or alternatively, within half an hour by the waiting room nurse, at PCH, when children present with gastrointestinal symptoms. This will ensure there is an early benchmark to measure the child's progress and monitor for signs of sepsis.

CAUSE AND MANNER OF DEATH

501. There was no dispute in the evidence that Dr Vagaja's opinion as to the cause of death was correct. Accordingly, I accept and adopt Dr Vagaja's opinion that the cause of death was multiorgan failure due to fulminant sepsis (*Streptococcus pyogenes*).[630]

502. Dr Vagaja expressed the opinion the manner of death was consistent with natural causes.[631] That is consistent will all of the evidence before me and no submission was made to counter that opinion. Accordingly, I find the death occurred by way of natural causes.

[629] T 494 – 495.
[630] Exhibit 1, Tab 4 and Tab 5.
[631] Exhibit 1, Tab 5.

CONCLUSION

503. Many of the staff indicated in their statements and their evidence at the inquest that they had been deeply affected by the news of Aishwarya's death. People such as Ms Wells, Nurse Vining and Ms Newton-Cremers, all spoke of the trauma of the night. Some staff were too traumatised to even participate in person at the inquest. Dr Hollaway made his own personal statement to Aishwarya's parents about how heartbroken he was that he couldn't save Aishwarya at the end. I accept the evidence given by Dr Wood and Dr Anwar on behalf of CAHS that no staff member who has been involved in this matter at any level has been left untouched.

504. However, it is Aishwarya's parents and greater family who have suffered the greatest and most catastrophic loss. No one who has borne witness to Aswath's and Prasitha's conduct on the night in the CCTV trying to get help for Aishwarya could doubt their genuine concern and unwavering love for her. Their profound grief following the events on that fateful night has been felt by every parent in this State and wider.

505. Aishwarya's parents provided a statement to be read into the evidence, and I include that here, as a way for them to speak in their own words about the impact Aishwarya's death has had upon them:[632]

> *[A]s responsible parents, we have always given all the opportunity to our daughter, Aishwarya, to flourish in life. She was full of life, always happy to be around, always positive. Our daughter had big dreams in life and always dreamt of becoming a teacher. She often said, "When I grow up, I want to be a teacher."*
>
> *She was, in fact, a teacher for her younger brothers. She also became the youngest ever teacher because of the circumstances of her death that should serve as a lesson for all of us to abide by and learn from. And this is especially so for our West Australian health system. Why should our health system change only after losing an innocent little life? What did Aishwarya do wrong? Why did she have to pay the ultimate price?*
>
> *We will never forgive our health system and people associated with it. Since Aishwarya passed away, there has not been a day without tears in our eyes. Your Honour, all we want, as a family, is for the truth to come out, and we want to see meaningful and sustainable change in our health system to that this doesn't happen again, and so no other parent is put through a similar situation.*

506. I understand why they will never forgive the health system and those involved in it for the death of their beautiful daughter, but they conducted themselves with grace and dignity in these proceedings and put their focus on the system rather than individuals. Their position demonstrated a true generosity of spirit and an understanding of the need for the coronial system to focus on death prevention rather than blame. Their unwavering commitment to see this matter through, despite the undoubted pain having

[632] T 788.

to attend and hear the evidence every day caused them, must be recognised. Their bravery in the face of tragedy has been acknowledged by all involved.

507. Since this inquest, I am aware that Aishwarya's family have had the blessing of the birth of a new baby daughter/sister into their family. While of course Aishwarya can never be replaced, I hope the new addition to their family brings some much needed joy into their lives after so much sadness.

508. I hope that Aswath, Prasitha and all of the Chavittupara family, including Baby Aishwarya, see this finding as the completion of one part of their journey in learning to live with the loss of Aishwarya, and that they can feel that their advocacy on her behalf has made a difference to the community of Western Australia. Her legacy will be ever present in the lives of other parents of sick children when they can use the pink phone to make Aishwarya's CARE Call, something that was not available to them on that fateful night.

509. Many important changes have been implemented since these sad events, and I have no doubt many more will be made. There was evidence the State Government has injected a large amount of additional funds, in the millions, to implement these changes. All of these are positive things. However, it is important to reflect on the question that counsel for Aishwarya's parents asked of Dr Wood. Mr Hammond asked Dr Wood whether he agreed with Aswath and Prasitha that it shouldn't have taken Aishwarya's death for these changes to be made? Dr Wood responded candidly, "I would absolutely agree with that. Yes."

510. I think every member of the community would agree with the answer to that question. It shouldn't take the death of a beloved little girl for the Department of Health, and the Government, to stop and consider what more it can do, and how much more money it should spend, to keep children safe when they visit our specialist children's hospital. We are fortunate as a State to have come out of the pandemic in a relatively healthy financial position, and while I acknowledge there are many competing demands on the public purse, the health of our community, and particularly our children, must be a priority. That means spending money on providing a positive practice environment for the nurses, doctors and support staff who run these hospitals, and in particular PCH. There is no point in having a state of the art facility, if the staff working within it are stretched beyond capacity and parents lose their trust and faith in them.

S H Linton
Deputy State Coroner
22 February 2023