[2020] WACOR 42

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Barry Paul King, Deputy State Coroner
HEARD	**:**	5-6 AUGUST 2019, 2 SEPTEMBER 2019 AND 19 FEBRUARY 2020
DELIVERED	**:**	1 DECEMBER 2020
FILE NO/S	**:**	CORC 1239 of 2015
DECEASED	**:**	BEMBRIDGE, TAHLIA ROSE

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr D P Jones assisted the Coroner on 5 August 2019, 6 August 2019 and 2 September 2019
Ms K A Heslop assisted the Coroner on 19 February 2020
Mr J F Bennett (State Solicitor's Office) appeared for the WA Country Health Service
Ms H M Cormann appeared for the Royal Flying Doctor Service WA
Ms C A Elphick (Dominion Legal) appeared for Dr H Graham
Ms B E Burke (Australian Nursing Federation) appeared for J Berryman EN, S Burns RN and T Murphy CN
Ms M J Naylor (Tottle Partners) appeared for Dr N Kling, Dr A Pardhan and Dr M Smith

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Barry Paul King, Deputy State Coroner, having investigated the death of ***Tahlia Rose BEMBRIDGE*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 5-6 August 2019, 2 September 2019 and 19 February 2020, find that the identity of the deceased child was* ***Tahlia Rose BEMBRIDGE*** *and that death occurred on 2 October 2015 at Princess Margaret Hospital from volvulus of the large intestine in the following circumstances:*

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INTRODUCTION

1. Tahlia Rose Bembridge died on 2 October 2015 at Princess Margaret Hospital (PMH) after being transferred from Bunbury Hospital by the Royal Flying Doctor Service Western Australia (RFDS) and St John Ambulance (SJA). She was four years old and had Down syndrome.

2. Tahlia had presented at the Bunbury Hospital emergency department (ED) with her mother Candice Bembridge in the early hours of 1 October 2015. She had symptoms of a possible bowel obstruction.

3. Investigations at Bunbury Hospital excluded acute bowel obstruction, and Tahlia's condition improved during the day, but she was still unwell. At about 4.00 pm that afternoon, the doctors managing her decided to transfer her to PMH where she could receive specialist paediatric surgery if her condition deteriorated (the transfer). They called the RFDS who arranged for an aircraft crew to pick her up that evening.

4. At about 7.30 pm, SJA officers took Tahlia to Bunbury Airport, and she was transferred onto the RFDS aircraft. At about that time, her condition deteriorated abruptly. The RFDS crew flew her to Jandakot Airport, and she was met by an emergency medical team who resuscitated her and transferred her to PMH by SJA.

5. At PMH, Tahlia's condition deteriorated further. Her heart arrested at about 11.00 pm, and despite full resuscitation attempts she could not be revived.

6. Chief Forensic Pathologist Dr C T Cooke performed a post mortem examination and identified a volvulus (twisting) of the large intestine as the cause of Tahlia's death.

7. In December 2015 and January 2016, the WA Country Health Service (WACHS) and the Children and Adolescent Health Service (CAHS) conducted a root-cause analysis in order to identify issues that may have contributed to Tahlia's death and to make recommendations directed towards rectifying any shortcomings.

8. On 17 February 2016, Tahlia's maternal grandfather, Paul Williams, contacted the Court and requested that an inquest be held into Tahlia's death. He believed that the staff at Bunbury Hospital were aware that Tahlia was in a critical condition at 3.30 pm.[1]

9. Mr Williams contacted the Court again in June 2016 to express his impatience with the lack of activity in relation to an inquest. He explained that his particular concern was with SJA having an exclusive right to transfer patients in country areas, which he saw as being fundamental to Tahlia's death.

10. Following a preliminary investigation, on 24 February 2017 the State Coroner approved Mr William's request for an inquest. At that stage, the issues requiring investigation were identified as:

    a. an apparent failure at Bunbury Hospital to recognise the severity of Tahlia's condition, including a failure to identify signs of sepsis;

    b. the delay in transferring Tahlia to PMH once the decision to transfer her had been made; and

    c. an apparent failure at Bunbury Hospital to stabilise and prepare Tahlia for the transfer.

11. Unfortunately, there was then a long delay in obtaining documents and reports from the agencies and individuals who had information relevant to Tahlia's care. On 5 August 2019 and 6 August 2019, I held an inquest at the Perth Coroner's Court. The documentary evidence adduced on those days included:

    a. a two-volume brief of evidence comprising statements, reports and records;[2] and

    b. two photographs of Tahlia and her family.[3]

[1] 19/2/20 ts 13
[2] Exhibits 1.1 and 1.2
[3] Exhibit 2

12. Oral evidence was provided by (in order of appearance):

    a. Dr Sumudu Jayasekera, a junior doctor in the paediatric team at Bunbury Hospital who called the RFDS to request the transfer;[4]

    b. Dr Harvey Graham, a consultant paediatrician at Bunbury Hospital who treated Tahlia;[5]

    c. Dr Nicholas Enzor, an RFDS doctor who managed Tahlia on the aircraft from Bunbury to Jandakot;[6]

    d. Dr Paul Bailey, an emergency physician and the medical director of SJA;[7]

    e. Dr Hakan Yaman, an emergency medicine consultant and clinical coordinator with the RFDS who spoke to Dr Jayasekera to arrange for the transfer;[8]

    f. Dr Christopher Blyth, the head of the department of infectious diseases at Perth Children's Hospital and an associate professor of paediatrics who provided an independent expert report in relation to Tahlia's care;[9]

    g. Professor Stephen Langford, the director of medical services at the RFDS at the time of Tahlia's death;[10]

    h. Kerry Winsor, the regional director of WACHS in the South West (WACHS-SW);[11] and

    i. Katie McKenzie, executive director of nursing services at CAHS.[12]

[4] 5/8/19 ts 7-23
[5] 5/8/19 ts 23-66
[6] 5/8/19 ts 67- 88
[7] 5/8/19 ts 89-100
[8] 5/8/19 ts 100-119
[9] 6/8/19 ts 123-158
[10] 6/8/19 ts 158-180
[11] 6/8/19 ts 123-158
[12] 6/8/19 ts 199-207

13. During the course of the evidence on 6 August 2019, it became apparent that further witnesses would be required to investigate the role of surgical and nursing staff in Tahlia's care at Bunbury Hospital. For that reason, following Ms McKenzie's evidence, I adjourned the inquest in order to arrange for further witnesses to give evidence at a later date.

14. The hearing of the inquest recommenced on 2 September 2019. The following additional documentary evidence was adduced:

    a. a copy of the Paediatric Acute Recognition & Response Observation Tool 1-4 Years (Parrot chart);[13]

    b. a statement of Dr Kavitha Lakshminarayanan, the acting executive director of Child and Adolescent Mental Health Service;[14]

    c. a statement of Clinical Nurse Tania Murphy;[15]

    d. a statement of Enrolled Nurse Jodie Berryman;[16] and

    e. a statement of Registered Nurse Sandra Burns.[17]

15. Oral evidence was provided by three nurses who had been on duty in the paediatric unit of Bunbury Hospital when Tahlia was admitted there (in order of appearance):

    a. Nurse Murphy;[18]

    b. Nurse Berryman;[19] and

    c. Nurse Burns.[20]

[13] Exhibit 3
[14] Exhibit 4
[15] Exhibit 5
[16] Exhibit 6
[17] Exhibit 7
[18] 2/9/19 ts 211-227
[19] 2/9/19 ts 228-238
[20] 2/9/19 ts 239-249

16. After Nurse Burns' oral evidence, the inquest was adjourned until 19 February 2020. On that date, the following documentary evidence was adduced:

    a. a series of six photographs of Tahlia taken by Mrs Bembridge at the hospital and on the aircraft;[21]

    b. a statement of Mr Williams;[22]

    c. a statement of Dr Neill Kling, the head of surgery at Bunbury Hospital in 2015;[23]

    d. a statement of Dr Mark Smith, consultant surgeon who was responsible for Tahlia's care at Bunbury Hospital;[24]

    e. RFDS statistics of patients 'going in' for Bunbury versus all WA inter-hospital transfers 2012/2013 to 2015/2016;[25]

    f. a letter from Ms Naylor clarifying the statement of Dr Parhan, a surgical registrar at Bunbury Hospital who examined Tahlia;[26] and

    g. a statement of Janet Foreman, Senior Registered Nurse, Clinical Risk Coordinator, WACHS-SW.[27]

17. Oral evidence was provided on 19 February 2020 by (in order of appearance):

    a. Mr Williams;[28]

    b. Dr Pardhan;[29]

    c. Dr Kling;[30]

[21] Exhibit 8
[22] Exhibit 9
[23] Exhibit 10
[24] Exhibit 11
[25] Exhibit 12
[26] Exhibit 13
[27] Exhibit 14
[28] 19/2/20 ts
[29] 19/2/2020 ts 26-45
[30] 19/2/2020 ts 46-76, 104-116

d. Dr Smith;[31] and

e. Mrs Bembridge.[32]

18. Following the oral evidence, I indicated to counsel that I did not intend to make adverse comments about any of their clients. Notwithstanding my stated intention, Tahlia's family and counsel for the interested parties provided very helpful written submissions for which I am grateful.

19. I have found that, in hindsight, the care provided to Tahlia at Bunbury Hospital was not optimal because it lacked more frequent observations and ongoing medical review once the decision had been made to transfer her to PMH. However, I am satisfied that the crucial decisions made by the clinicians responsible for her care were reasonable in the relevant circumstances.

20. Since Tahlia's death, WACHS has made significant improvements to several aspects of patient management, including improvements to inter-hospital transport of patients, which may reduce the likelihood that another child will die in similar circumstances.

TAHLIA ROSE BEMBRIDGE

21. Tahlia was born at Bunbury Hospital on 2 September 2011. She was her parents' second child.[33]

22. On the night of 3 September 2011, Tahlia was transferred by the Newborn Emergency Transport Service (NETS) on an RFDS aircraft from Bunbury Hospital to PMH due to concerns of possible Down syndrome, possible sepsis, and a delay in the passage of meconium, indicating possible bowel obstruction.[34]

[31] 19/2/2020 ts 77-104
[32] 19/2/2020 ts 116-118
[33] Exhibit 1.1.28
[34] Exhibit 1.1.28

23. Tahlia remained at PMH for two weeks. She was found to have no bowel obstruction, but Down syndrome was confirmed and she was also diagnosed with minor cardiac issues which resolved spontaneously. She was transferred back to Bunbury Hospital on 13 September 2011.[35]

24. In October 2011, Tahlia and her family moved to Karratha, where they lived until July 2014 when they moved back to the South West. In September 2015, they were living in Australind.

25. In November 2012, Tahlia was visiting relatives in Tasmania with her family when she underwent emergency surgery at Royal Hobart Hospital for acute mid-gut volvulus. The surgery apparently included the creation of scar tissue to keep the bowel from rotating again. She was discharged after a week, with no ongoing problems.[36]

26. Tahlia had also undergone tonsillectomy, adenoidectomy and insertion of grommets.[37] She could only say a few words, but she would communicate with signals.[38]

27. It is clear that Tahlia was a cherished member of a loving close-knit family and extended family.[39]

BUNBURY HOSPITAL ED

28. On the morning of 30 September 2015, Mrs Bembridge took Tahlia and her younger sister to a park where there were other mothers with children. Tahlia was happy and was playing. In the afternoon, they returned home and Tahlia had a nap. Later that evening, she ate only a small amount of her dinner.[40]

[35] Exhibit 1.1.28
[36] Exhibit 1.1.8.1; Exhibit 1.1.28
[37] Exhibit 1.1.9
[38] Exhibit 1.1.8.1
[39] For example: 19/2/2020 ts 117-118
[40] Exhibit 1.1.8.1

29. At about 10.30 pm on 30 September 2015, Tahlia vomited some of her dinner and became unsettled. She vomited again at about midnight and started displaying signs of pain and distress. At about 3.00 am on 1 October 2015, Mrs Bembridge took her to Bunbury Hospital ED where she was triaged at 3.36 am. At some stage, a nurse put a dressing on Tahlia's thumb because it was bleeding from her chewing on it due to the pain.[41]

30. The progress notes and other records made while Tahlia was in the Bunbury Hospital are sparse, and several entries were done in retrospect. The following account of Tahlia's early presentation to the ED is based primarily on a letter to the Court from Dr Allison Johns, Director of Medical Services, WACHS-SW.[42]

31. At 3.46 am on 1 October 2015, ED medical officer Dr Peter Stickler reviewed Tahlia and obtained from Mrs Bembridge Tahlia's history of presenting complaint of vomiting, clutching her abdomen, and experiencing pain in two-minute fluctuations. Dr Stickler noted that Tahlia had a normal bowel motion and normal amounts of urine on 30 September 2015 and that she had a past history of Down syndrome and incarcerated bowel as a neonate. Tahlia's observations were all within normal limits although they included a heart rate of 130 beats per minute and a respiratory rate of 37 breaths per minute. She appeared well-perfused and of good colour and hydration.[43]

32. Dr Stickler examined Tahlia and found that her abdomen was soft and mildly tender with no rigidity, guarding or rebound tenderness to suggest an 'acute abdomen'; that is, rapid onset of potentially life-threatening intra-abdominal pathology requiring surgical intervention. He checked for intussusception, a condition where the bowel telescopes on itself and causes obstruction,[44] and the signs were negative. He formed the impression that Tahlia had non-specific gastroenteritis, but he recommended a period of

[41] Exhibit 1.1.27; Exhibit 1.1.8.1
[42] Exhibit 1.1.32
[43] Exhibit 1.1.32; Exhibit 1.1.27
[44] 5/8/19 ts 53

observation to rule out intussusception.[45] At 4.15 am, Tahlia was given a pain score of 'moderate'.[46]

33. At about 4.30 am, Dr Stickler reviewed Tahlia and noted that there had been no progression of her symptoms but that she still had pain at two minute intervals. He prescribed an anti-emetic, and over the next hour he prescribed paracetamol and then intra-nasal fentanyl for her pain. Her pain scores were recorded as 'severe' at 5.20 am and 5.40 am, but they decreased to 'mild' by 6.10 am and did not increase again. From 8.00 am, her pain scores were 'nil'.[47]

34. At about 5.40 am, an ED medical officer, presumably Dr Stickler, called the on-call paediatric advanced trainee, Dr Lydia So, and informed her of Tahlia's presentation. Dr So advised the ED doctor to refer Tahlia to the surgical team because one of the differential causes of presentation with abdominal pain is an acute abdomen.[48]

35. At 6.15 am, surgical registrar Dr Pardhan reviewed Tahlia and noted her past history of Down syndrome and malrotation of the bowel as an infant. Mrs Bembridge informed him that Tahlia had experienced colicky abdominal pain and two episodes of vomiting, and that she had been opening her bowels until the previous day.[49]

36. After examining Tahlia's abdomen and finding it distended but not tender, Dr Pardhan reached a provisional diagnosis of possible obstruction from adhesions. He ordered routine blood tests, abdominal ultrasound and X-rays, and he planned for a review by the surgical consultant, Dr Smith. He considered that it was necessary for Tahlia to be admitted for observation because, in a case of presumed adhesive bowel obstruction, it is a matter of waiting. If a patient does not settle in 24 to 48 hours, surgery is required.[50]

[45] Exhibit 1.1.32
[46] Exhibit 1.1.27
[47] Exhibit 1.1.32; Exhibit 1.1.27
[48] Exhibit 1.1.10
[49] Exhibit 1.1.11
[50] Exhibit 1.1.11; 19/2/20 ts 28-29

37. Between 7.00 am and 8.00 am on 1 October 2015, Dr Pardhan called Dr Smith to tell him about the overnight admissions. Dr Smith was to be in theatre until midday, so they arranged for him to review Tahlia after that.[51]

38. At 8.25 am, ED staff consulted with a paediatric registrar to advise that Tahlia's blood-sugar level was elevated and to suggest a further attempt at IV cannulation to collect formal bloods.[52]At around 8.30 am, Dr Pardhan told Dr Kling, who was doing the ward rounds that morning, that he was concerned about Tahlia and asked him to review her in her bed in the ED.[53]

39. Dr Kling examined Tahlia and considered that she was not shocked, distressed or toxic, but that she was not happy. Her observations were stable. She did not have symptoms of peritonitis (inflammation of the membrane lining the abdominal wall) but she possibly had some left iliac fossa discomfort on deeper palpation. It was difficult to be sure because Tahlia was non-verbal. Dr Kling was also informed about Tahlia's high blood-sugar level.[54]

40. Dr Kling thought that Tahlia had incomplete adhesive small bowel obstruction that might resolve on conservative management. He said in oral evidence that a caecal volvulus was far from his mind because the previous surgery that she had in Tasmania should have precluded it.[55] He said that the blood test results which became available later did not show any sign of dehydration and, though the lactic acid level was elevated, it did not indicate lactic acidosis.[56]

41. Dr Kling agreed with the plan to order an abdominal X-ray, an ultrasound scan and blood tests. He advised Dr Pardhan that:[57]

    a. Dr Smith would need to be consulted;

    b. Tahlia should be restricted to clear fluids;

[51] Exhibit 11 2
[52] Exhibit 1.1.32
[53] 19/2/20 ts 29
[54] Exhibit 10
[55] 19/2/20 ts 50
[56] 19/2/20 ts 51
[57] Exhibit 10

c. paediatricians should be involved in her management, particularly in relation to her high blood sugar;

d. PMH should be consulted about the need for a transfer; and that

e. if Mrs Bembridge or any of the clinicians had any concerns, Tahlia should be transferred to PMH.

42. At 9.30 am, Dr Kling discussed Tahlia's case with Dr Lila Stephens, the head of the paediatric department at Bunbury Hospital. Dr Stephens agreed that paediatricians should be involved and that contact with PMH was essential.[58]

43. After speaking with Dr Stephens, Dr Kling called Dr Pardhan and re-emphasised the need to call PMH about Tahlia. Dr Pardhan informed him that the X-ray of Tahlia's abdomen showed faecal loading of the large bowel with prominence of small bowel loops, but no features of small bowel or large bowel obstruction.[59]

44. Before 10.30 am, Dr Pardhan called Dr Kling to tell him that the ultrasound scan showed peristalsis and no signs of intussusception, but it suggested mesenteric adenitis (swollen lymph glands in the abdomen). He also told Dr Kling that he had spoken to a surgical registrar at PMH who advised that it would be appropriate to monitor Tahlia at Bunbury Hospital but to transfer her if she deteriorated with abdominal tenderness or haemodynamic instability.[60]

45. At about 10.30 am, Dr Graham reviewed Tahlia in the ED after a request for a paediatric review in view of her elevated blood sugar level. She was still in the ED because she was awaiting a bed in the paediatric ward where she was to be admitted under Dr Smith's care. He noted that she had a high lactate level in her blood gas at 7.00 am but that she was clinically improving.[61]

[58] Exhibit 10
[59] Exhibit 10
[60] Exhibit 1.1.11; Exhibit 10
[61] 5/8/19 ts 33

46. Dr Graham examined Tahlia while she cuddled Mrs Bembridge. She was alert but quiet without being in obvious pain. Her respirations were 30, she was afebrile, her heart rate was 110-120, her blood pressure was 90/50 and her capillary return was less than 3 seconds. She appeared pale. Her abdomen was slightly full and Dr Graham could feel the faecal masses. Her abdomen was not tender and had no guarding or rebound tenderness. He was concerned about a recurrence of twisted bowel and wanted to exclude it as a possibility.[62]

47. Dr Graham gained the impression that Tahlia had constipation. He prescribed a laxative and a fleet enema to be administered when she arrived at the paediatric ward.[63]

BUNBURY HOSPITAL PAEDIATRIC WARD

48. Tahlia was registered as admitted to the paediatric ward at 11.27 am, though entries in the progress notes indicate that she arrived there a bit earlier. A short time after arriving at the ward, she had a couple of vomits.[64]

49. At midday, Nurse Berryman took Tahlia's observations and saw that she was quiet, pale and lethargic.[65]

50. At around 12.15 pm, Nurse Berryman re-attended Tahlia, who had just had a large vomit in bed, apparently from the water she had drunk. The vomit also included a streak of old blood, possibly from the wound Tahlia made on her thumb[66] or from tears to her oesophagus from earlier vomiting.[67] In oral evidence, Nurse Berryman said that the old blood was consistent with someone who has had a lot of previous vomits.[68]

[62] Exhibit 1.1.27; Exhibit 12; 5/8/19 ts 24
[63] Exhibit 1.1.27
[64] Exhibit 1.1.27
[65] 2/9/2019 ts 231
[66] Exhibit 6; Exhibit 1.1.27
[67] 5/8/19 ts 56
[68] 2/9/2019 ts 232

51. At about 12.30 pm, Dr Smith reviewed Tahlia with Dr Pardhan. Dr Smith reviewed the X-ray and ultrasound results and assessed her observations as stable. On examination, he found some tenderness in her left iliac fossa when he pressed on it. He made a provisional diagnosis of incomplete or partial bowel obstruction and ordered that Tahlia be placed on intravenous fluids and be monitored. She was to be transferred to PMH if she deteriorated, and she was to be given glycerine suppositories.[69]

52. Dr Smith said in oral evidence that her abdominal tenderness was the only particular concern he had for Tahlia, but he had a lot of difficulty assessing her because she was non-verbal and because Down syndrome patients have other significant medical conditions of concern. He had to rely to a large extent on the investigations in order to assess her.[70]

53. Dr Smith said that he had been concerned about Tahlia and had considered transferring her to PMH at that time, but she appeared to be stable, she had been examined by Dr Kling and Dr Graham, who had initiated some treatment, and the advice from PMH was that she could be kept in Bunbury and observed. He said that the tenderness he found in her abdomen was not a change since she had presented to the ED with abdominal pain.[71]

54. It appears from the paediatric observation and response chart kept for Tahlia in the paediatric ward that, from midday, almost all Tahlia's vital signs remained stable until 6.50 pm that evening. Her respiratory rate was about 25, her respiratory distress level was normal, her oxygen saturation was 98% or 99%, her systolic blood pressure was about 92, her consciousness level was 'alert', her pain score was 'nil' and her temperature had increased from 35.5° at 12.00 pm to about 36.5° at 1.40 pm and 6.50 pm. All of those signs were normal. However, her heart rate had increased incrementally from 125 at 12.00 pm to around 140 by 6.50 pm.[72]

[69] Exhibit 1.1.11; Exhibit 1.1.27; Exhibit 11
[70] 19/2/2020 ts 80-81
[71] 19/2/2020 ts 82, 92
[72] Exhibit 1.1.27

55. At 1.30 pm, a surgical intern inserted an intravenous cannula on the first attempt and Tahlia showed minimal response during the procedure. A blood sample was taken for further limited testing and Tahlia was provided intravenous fluid in accordance with Dr Smith's instruction.[73] From that time, a nurse checked the intravenous line every hour, so Tahlia was attended regularly. If a nurse had noticed a significant change, she would have contacted a doctor.[74]

56. At some time, Dr Graham was in the paediatric ward, and he asked nursing staff if Tahlia had been drinking fluids. He was informed that she had got up and walked to the toilet to have a bowel motion. That was reassuring to him. Dr Graham thought that he was told of the bowel motion before midday,[75] but the nursing records indicates that it did not occur until after 2.00 pm, [76] which accorded with Nurse Murphy's recollection.[77]

57. At about 3.15 pm, a paediatric resident medical officer informed Dr Graham that Dr Smith had earlier diagnosed Tahlia with sub-acute bowel obstruction and had indicated that he would suggest transferring her to PMH if she deteriorated. Dr Graham reviewed Tahlia at 3.30 pm and viewed her observations. He examined her and thought that her abdomen felt tender, which it had not been earlier. Her abdominal distention and fullness had not improved and he did not hear any bowel sounds.[78] He found no rebound tenderness.[79]

58. On the basis of his review, Dr Graham planned to continue with clear fluids, laxatives and intravenous fluids. He ordered repeat blood tests for the next morning and noted that, if Tahlia had persisting or bile-stained vomiting, she was to be transferred to PMH. He also planned to discuss her case with the surgeons, presumably Dr Smith.[80]

[73] Exhibit 7; Exhibit 1.1.27
[74] 19/2/2020 ts 84; Exhibit 7 4
[75] 5/8/19 ts 29, 54
[76] Exhibit 1.1.27
[77] Exhibit 5 3
[78] Exhibit 1.1.12
[79] Exhibit 1.1.27
[80] Exhibit 1.1.27

59. However, shortly after Dr Graham reviewed Tahlia, she had a coffee-ground vomit and he found that her abdomen seemed increasingly tender. He called Dr Smith and they agreed that she should be transferred to PMH in case she deteriorated and required an operation under anaesthetic.[81]

60. Dr Graham asked Dr Jayasekera to contact the RFDS to request Tahlia's transfer as soon as possible. He told her that Tahlia was stable but that she had deteriorated slightly since his earlier review of her condition and had now developed increased abdominal tenderness and another vomit.[82]

61. Dr Jayasekera called the RFDS and spoke to Dr Yaman. She told him that Tahlia had a history of malrotation in the past and that an X-ray and an ultrasound scan did not show any evidence of malrotation but possible obstruction. She said that Tahlia was fairly stable but was vomiting intermittently, her tummy was a bit distended and she was not in a lot of pain. Dr Jayasekera said that Tahlia's respiratory rate was 25, her oxygen saturation was 100%, her pulse was 140 and her blood pressure was 95/50. She confirmed that there was an intravenous line and that Mrs Bembridge would be travelling with Tahlia.[83]

62. Dr Yaman allocated Tahlia a 'Priority 2' rating and told Dr Jayasekera that the RFDS would try to pick up Tahlia early that evening.[84] The aircraft would take her to Jandakot Airport, and an ambulance would meet the aircraft and take her on to PMH.

63. At 4.45 pm, Dr Graham called the RFDS and spoke with another co-ordinator, Robert O'Brian, in order to find out the time the aircraft was likely to arrive so that he could advise Mrs Bembridge whether she had time to go home to collect some things to take to Perth. Mr O'Brian said that they would not be arriving till around 7.30 pm, and Dr Graham said that was fine.[85]

[81] Exhibit 1.1.27 19/2/2020 ts 87
[82] Exhibit 1.1.13
[83] Exhibit 1.1.19.7
[84] Exhibit 1.1.19.7
[85] Exhibit 1.1.19.7

64. From 5.00 pm until 6.50 pm, Tahlia's condition remained fairly stable, with the only change being an increase in her heart rate to about 145. She continued to receive maintenance amounts of fluid.[86] She was not reviewed by a doctor during that time because Dr Graham and Dr Jayasekera were in the operating theatre.[87]

65. At one point, Mrs Bembridge told Nurse Burns that Tahlia was sore, so Nurse Burns called Dr Jayasekera and obtained an order for paracetamol, which she then administered intravenously.[88]

66. At about 7.30 pm, SJA officers attended Bunbury Hospital to pick up Tahlia to take her to Bunbury Airport. She had a small vomit, so Nurse Burns administered intravenous anti-emetic which Dr Jayasekera charted.[89] Nurse Burns checked the intravenous line and ensured that it was functioning correctly. She also recorded that the cannula site in Tahlia's elbow crease had no issues and that Tahlia had a wet nappy. She noted that Tahlia looked flat, with a pulse of 138, a respiratory rate of 22, and a blood pressure of 92/50.[90]

67. When the SJA officers connected Tahlia to their automated monitoring at 7.40 pm, she had a pulse of 130, systolic blood pressure of 95, respiration rate of 20, oxygen saturation of 99% and temperature of 37.30°. They noted that her breathing and skin condition were both unremarkable, her pulse was regular and her capillary refill was less than 2 seconds. She was lethargic, tired and pale.[91]

68. The SJA officers left Bunbury Hospital with Tahlia and Mrs Bembridge at 7.44 pm and arrived at the patient transfer centre at Bunbury Airport at 7.52 pm. The automated monitoring equipment showed no change to Tahlia's condition apart from a 0.5° increase in her temperature to 38.20°.[92]

[86] Exhibit 1.1.27; Exhibit 7 3
[87] Exhibit 1.1.
[88] Exhibit 7 2-3
[89] Exhibit 7 3; Exhibit 1.1.27
[90] Exhibit 1.1.27
[91] Exhibit 1.1.22
[92] Exhibit 1.1.22

69. Another patient, a 79 year old woman with a stroke, was also being transferred on the RFDS aircraft. She was at risk of needing airway support during the flight, so a doctor, in this case Dr Enzor, was required. Tahlia was not expected to need a doctor's assistance, but Flight Nurse Ray Wyeth would have been able to attend to her.[93]

BUNBURY AIRPORT

70. When the RFDS aircraft landed at Bunbury Airport at 7.50 pm, Dr Enzor went to the patient transfer centre to take handover of Tahlia and the other patient from the SJA officers. The patient transfer centre was a small bare room with a stretcher, a couch and a kettle. A patient could be taken by SJA officers into the centre on a stretcher and then be moved onto an RFDS stretcher in relative comfort and lighting.[94]

71. When Dr Enzor went to the patient transfer centre, he immediately realised that Tahlia was in much worse condition than he had expected. She had mottled skin, indicating that her body was not supplying blood to the tissues. He assessed her as being very sick as she was pale, mottled and cool peripherally, and she had a distended tender abdomen with guarding, indicating peritonitis.[95]

72. Dr Enzor took a brief handover from the SJA officers and asked Nurse Wyeth to move Tahlia onto the RFDS stretcher while he took a handover from other SJA officers in relation to the other patient. Once both patients were on the aircraft, Tahlia was connected to the monitoring equipment and Dr Enzor could see that her heart rate was 179 and her blood pressure was 53/30. His impression was that she was dehydrated and hypovolemic with septic shock.[96] Before the take-off, he instructed Nurse Wyeth to give her an intravenous bolus of fluid and intravenous antibiotics, but the pump attached to the intravenous line would not deliver

[93] Exhibit 1.1.16
[94] 5/8/2019 ts 70-71
[95] Exhibit 1.1.16; 5/8/2019 ts 71
[96] Exhibit 1.1.16; 5/8/2019 ts 71

the fluids.[97] He believed that the likely treatment for Tahlia was to get her to PMH for an operation as quickly as possible.[98]

73. The pilot then asked Dr Enzor and Nurse Wyeth if they were ready for take-off. Nurse Wyeth asked for a couple of minutes to sort out the intravenous pump, but he was unable to solve the problem quickly. They agreed to take off and to rectify the problem during the flight. They took off at 8.35 pm.[99]

74. During the flight, the other patient, who was positioned on the front stretcher in the aircraft, became nauseous and her blood pressure dropped. Dr Enzor was sitting next to her and was able to attend to her. He was also in continuous contact with Nurse Wyeth, who advised that Tahlia's arm was swollen near the cannula, indicating that the fluid was going into her tissues instead of the vein. It was important to insert another intravenous line, but Tahlia then vomited.[100]

75. Dr Enzor moved next to Tahlia and used a sucker to remove as much vomitus from her mouth as he could. He then rolled her on her back and became concerned that her respiratory rate had increased to 50 and the oxygen saturation probe was not picking up oxygen. He thought that she may have aspirated, so they gave her supplemental oxygen and prepared to re-site an intravenous line for rehydration fluids and antibiotics. However, she then vomited again, which he managed by suction and by placing her on her side. At this time, the pilot announced 'top of descent', so Dr Enzor had to resume his seat. He asked the pilot to arrange for a doctor to meet them upon landing at Jandakot.

JANDAKOT AIRPORT

76. Dr Yaman met the aircraft when it arrived at Jandakot Airport at 9.15 pm. He assisted Dr Enzor to move Tahlia to the RFDS resuscitation bay while Dr Enzor explained Tahlia's circumstances. Dr Yaman called the RFDS Co-ordination Centre and asked for Dr Christina Stuke to assist him and Dr

[97] Exhibit 1.1.16
[98] 5/8/2019 ts 72
[99] Exhibit 1.1.16
[100] Exhibit 1.1.16

Enzor in the resuscitation efforts and to accompany Tahlia to PMH if required.[101]

77. The three doctors were unable to obtain venous access, but they eventually inserted an intra-osseous needle and were able to administer an urgent fluid bolus and antibiotics. Following the fluid bolus, Tahlia's condition improved and she started to cry, a positive development.[102]

78. The doctors then decided to transfer Tahlia to PMH because of airway difficulties inherent in inserting a nasogastric tube. Dr Stuke went in an ambulance with Tahlia and Mrs Bembridge while Dr Yaman contacted PMH and spoke to the expecting surgical registrar and to the admitting emergency consultant, Dr Helen Mead, to explain Tahlia's condition.[103]

PMH

79. When Tahlia arrived at PMH ED, she was taken directly to the resuscitation room, and Dr Mead took a focused history from Mrs Bembridge. Dr Mead and the treating emergency registrar, Dr Eleanor Lougheed, then took a handover from Dr Stuke. Dr Mead examined Tahlia and arrived at a working diagnosis of:

    a. sub-acute bowel obstruction (likely from adhesions from previous surgery) with hypovolemic shock due to inadequate fluid replacement for third space losses in gut;

    b. possible upper gastrointestinal haemorrhage (explaining the large brown/altered blood vomitus; and

    c. aspiration of vomitus with some respiratory distress.[104]

80. Dr Lougheed and a paediatric registrar then attended to Tahlia. They attempted to gain peripheral intravenous access, but at 10.55 pm Tahlia started vomiting, which required suction and being rolled onto her side.

[101] Exhibit 1.1.17 5
[102] Exhibit 1.1.17
[103] Exhibit 1.1.17
[104] Exhibit 1.1.9

When rolled back, she vomited again and was gasping for breath, so she was suctioned again. Dr Mead returned to assist, but at 11.07 pm Tahlia stopped breathing. Full CPR was commenced and assistance was requested from the intensive care unit and the anaesthetics department, but Tahlia's heart arrested.

81. Advanced life support then followed until 12.08 am on 2 October 2015, but Tahlia could not be revived.[105] An intensive care doctor completed a death notification form with the time of death as 12.25 am.[106] Mrs Bembridge had been with Tahlia throughout the resuscitation attempts.

CAUSE OF DEATH AND HOW DEATH OCCURRED

82. On 8 October 2015, Chief Forensic Pathologist Dr C T Cooke performed a post mortem examination of Tahlia's body and found bowel obstruction with bleeding into the intestine associated with ischaemia. The large intestine was twisted on its supporting tissue (volvulus) on the mid-region of the transverse colon. There was also possible aspiration of intestinal contents into the small airways. [107]

83. In specific terms, Dr Cooke found that the wall of the distal one third of the small intestine showed dusky discolouration, increasingly apparent towards the ileo-caecal junction, with this part of the intestine containing abundant red-coloured fluid. There was a volvulus in the large intestine at the mid-region of the transverse colon where there was a sharply demarcated area of dilatation and apparent ischaemia, extending proximally to the ileo-caecal junction. This part also contained abundant red-coloured fluid, with the mucosa showing dark purple colouration with thinning of the wall but no definite ulceration.[108]

84. On 21 January 2016, microscopic examination confirmed the presence of ischaemia of parts of the intestine. Testing for viral infection identified Enterovirus/Rhinovirus RNA and Parvovirus B19 DNA, probably incidental findings. Microbiology testing showed the presence of mixed

[105] Exhibit 1.1.9
[106] Exhibit 1.1.28
[107] Exhibit 1.1.6
[108] Exhibit 1.1.6

bacteria, not identifying a specific infection. Toxicology analysis showed medications consistent with recent medical care.[109]

85. Dr Cooke formed the opinion, which I adopt as my finding, that the cause of death was volvulus of the large intestine.[110]

86. I find that death occurred by way of natural causes.

DELAY IN THE TRANSFER FROM BUNBURY HOSPITAL TO PMH

87. From the time the request was made to the RFDS to transfer Tahlia, it took over five hours for her to arrive at Jandakot Airport[111] and another 15 minutes to get to PMH by ambulance.[112] Had Tahlia been transported by road ambulance from Bunbury, it would have taken significantly less time, possibly only two hours from the time of the request if an ambulance had been available in Bunbury.[113]

88. When Mr Williams wrote to the court to request an inquest, he suggested that the thrust of the inquiry would be to stop the exclusive contract that SJA had with WACHS to provide inter hospital transfers. He understood that Tahlia's condition was seen to be critical at 3.30 pm but that she had to wait for four hours for the RFDS when an ambulance could have taken her earlier. Given his understanding of the situation, it is not surprising that he was upset about the amount of time taken to transfer Tahlia to PMH. He said that the contract negated anyone apart from SJA assisting at times of need.[114]

89. Likewise, Dr Kling wrote to the WACHS-SW regional medical director in December 2015 to advocate for the use of ambulances for urgent inter-hospital patient transport. He said that SJA had only three ambulances in Bunbury and that all were needed for local transport, so SJA was reticent to devote an ambulance to transport of emergency patients to Perth. He noted that the RFDS supported his proposal and that a local private ambulance

[109] Exhibit 1.1.6
[110] Exhibit 1.1.6
[111] Exhibits 1.1.24 and 1.1.27
[112] Exhibit 1.1.22
[113] Exhibit 1.1.22
[114] Exhibit 1.1.7

service had been set up to provide an alternative which would be cheaper than SJA.[115]

90. A subsequent medical advisory committee consisting of the clinical heads of department at Bunbury Hospital also wrote to the executive of WACHS-SW requesting urgent consideration of the issue of patient transport between WACHS-SW hospitals and Perth hospitals, including careful consideration of a road-based transfer service.[116] The committee suggested that an audit was needed because there appeared to be an over-reliance on the RFDS for transport of stable patients and an under-use of ambulances.[117]

91. However, in July 2015, the government had implemented a patient transport strategy in which SJA would be used for all emergency road-based inter-hospital patient transport services. There was in-principle support for a phased approach commencing in 2018 to using other ambulance operators in selected areas.[118]

92. It is clear that a transfer by ambulance from Bunbury would have been far quicker than the transfer by RFDS aircraft. The evidence at the inquest established that:

    a. the fastest means of medical transport for Tahlia would have been by ambulance with medical escorts from Bunbury. That would have taken 1.5 to 2 hours depending on the traffic. If a medical team had to travel to Bunbury to escort Tahlia back to PMH, it would take two hours each way. An alternative could have been by helicopter, though it would have taken three to four hours for Tahlia to reach PMH;[119]

    b. in 2015, the RFDS in consultation with the doctors at Bunbury Hospital had the responsibility of arranging the mode of transport, including road ambulance transport, for inter-hospital transport of patients from Bunbury Hospital to Perth hospitals;[120]

[115] Exhibit 1.1.7.2
[116] Exhibit 1.1.7.2
[117] Exhibit 1.1.7
[118] Exhibit 1.1.7.3
[119] Exhibit 1.1.18.1
[120] 5/8/2019 ts 90, 159

c. in relation to possible road transport, the RFDS and SJA would have a discussion, with the patient's care requirement being the most important consideration.[121] If a doctor escort was required, a doctor from the originating hospital would have gone with the patient;

d. there were no impediments to SJA transporting Tahlia to PMH on 1 October 2015, and it would most likely have been with an ambulance based in Bunbury;[122]

e. had the doctors at Bunbury Hospital advised Dr Yaman that there was a sense of urgency in relation to Tahlia's condition, he could have allocated her a 'Priority 1' status and arranged for a quicker transfer by RFDS. About 90% of 'Priority 1' responses are less than an hour for the aircraft to leave Jandakot;[123]

93. That evidence indicates that the promptness of Tahlia's transfer from Bunbury Hospital to PMH depended primarily on the Bunbury Hospital clinicians recognising that she required urgent transfer because the level of urgency effectively determined the mode of transfer. In these circumstances, SJA's exclusive contract did not cause a delay in the transfer. Rather, the issue of the apparent delay in recognising the severity of Tahlia's condition needs to be considered.

DELAY IN RECOGNISING TAHLIA'S CONDITION

94. In October 2016 and November 2016, a panel of senior clinicians from King Edward Memorial Hospital, PMH and Bunbury Hospital (the panel) conducted an SAC 1 event multisite review (the SAC 1 review) of the root cause investigation by WACHS and CAHS. The panel focused on four contributory factors in Tahlia's preventable death.[124]

95. The first factor discussed by the panel was inadequate recognition and response to an unwell patient, especially a failure to recognise sepsis and the management of abdominal pain. The panel found that the severity of

[121] 5/8/2019 ts 90-91
[122] 5/8/2019 ts 96
[123] 5/8/2019 ts 104-106
[124] Exhibit 1.2.33

Tahlia's clinical condition was underestimated and that signs of sepsis were overlooked. However, neither the time when those signs were visible nor the nature of those signs was spelled out in the panel's report.

96. Dr Blyth also felt that the severity of Tahlia's condition was not recognised. He provided a report based on the Bunbury Hospital medical records and written accounts of the events. He believed that there were a number of concerning clinical features which, if recognised as pointing to severe intra-abdominal pathology, could have led to earlier transfer of Tahlia to PMH and thereby saved her life. Those features included:

    a. Tahlia's underlying history of Down syndrome and malrotation;

    b. Mrs Bembridge's concern on Tahlia's presentation;

    c. abdominal pain requiring opioid analgesia in the ED;

    d. evidence of lactic acidosis on the first venous blood gas analysis;

    e. progress tachycardia from presentation until review by the RFDS; and

    f. progressive abdominal pain, abdominal distention and blood-stained vomiting.[125]

97. At the time of completing his report, Dr Blyth was unaware of the observations taken by SJA officers at Bunbury Hospital and Bunbury Airport. As a result, he thought that there was uncertainty of Tahlia's progress from 4.00 pm to the time when Dr Enzor reviewed her. He considered it likely that Tahlia's deterioration had occurred during that time and that it was not recognised, which was of significant concern. He believed that, by the time Dr Enzor attended to her, she was in established shock and already had ischaemic gut and was in urgent need of surgery to reverse her volvulus.[126]

[125] Exhibit 1.2.29
[126] Exhibit 1.2.29

98. Dr Blyth said that, given the delay in recognising the severity of her condition, he was not convinced that she would have survived even if a dedicated paediatric retrieval service had gone to Bunbury to resuscitate, stabilise and transfer her to PMH.[127]

99. In writing his report, Dr Blyth was asked to comment on the management of sepsis or suspected sepsis for children in WA. After discussing the development of standard approaches at different centres in WA and New South Wales, he concluded that the use of a sepsis pathway (standardised approach for early recognition and management of sepsis) would not have prevented Tahlia's death because her presentation would not have triggered most of the existing sepsis pathways. In addition, triggering most sepsis pathways calls for review by senior clinicians, and she was reviewed by the most senior paediatric and surgical specialists in Bunbury and her condition was discussed with the surgical team at PMH.[128]

100. Dr Blyth thought that there was a failure to recognise and respond to Tahlia's illness but that it was not the fault of a single clinician; rather, it was a deficiency in WA's approach. He identified five areas that need to be developed in WA in order to establish acute care guidelines with early identification of physiologically-compromised patients.[129] I readily accept his opinion that such guidelines need to be developed, but I am unsure how his proposals would have applied to Tahlia's case specifically.

101. In oral evidence, Dr Blyth clarified the opinions expressed in his report. He said that the features of concern, or 'red flags', that occurred over the day on 1 October 2015 amounted to a constellation of factors which, when viewed in hindsight, seem to stack up. There was no single red flag; there were a number of factors that add up to a child who was clearly unwell.[130] He did not see one aspect of Tahlia's observations chart that needed to be addressed.[131]

[127] Exhibit 1.2.29 6
[128] Exhibit 1.2.29
[129] Exhibit 1.2.29
[130] 6/8/2019 ts 126, 137
[131] ts 136-137

102. Dr Blyth said that the information available early in the day should have led to significant concerns for intra-abdominal pathology and that, if surgical staff felt that they could not do something about that in Bunbury, the only other place was Perth.[132] He thought that Tahlia was at risk of rapid deterioration, but he did not think that it was clear that the deterioration could have been predicted.[133]

103. One sign that Dr Blyth considered significant was the abdominal tenderness found by Dr Smith at 12.30 pm. He said that it is difficult to detect tenderness in children of Tahlia's age and that trying to do so in a child with Down syndrome is challenging for any experienced paediatrician. That a surgeon felt that there was tummy pain was a concerning feature. [134] Dr Blyth saw that as the most significant change in Tahlia's clinical state throughout the day.[135]

104. Dr Blyth thought that, on the basis of the increase in Tahlia's heart rate with a relatively normal blood pressure, she was compensating for low blood pressure caused by a number of factors, including hypovolemia and possible bacterial infection. Both of those factors could have occurred as a result of the gut twisting.[136]

105. However, when Dr Blyth was referred to Tahlia's observations taken by the ambulance officers as compared to the observations taken by the RFDS on the aircraft, he agreed that there was an element of physiological stability until after about 8.15 pm, when there was a very quick and very acute deterioration. He was surprised at the rapidity of the deterioration given what we know about the pathology. He agreed that it was possible that Tahlia's intestine may have twisted again. He said that it is difficult, even looking back, to tease out all of the possibilities. She went from being at risk with a moderate degree of instability to profoundly shocked in a short time. He agreed that some crucial event had happened.[137]

[132] 6/8/2019 ts 138-139
[133] 6/8/2019 ts 141
[134] 6/8/2019 ts 128-129, 152
[135] 6/8/2019 ts 152
[136] 6/8/2019 ts 155-156
[137] 6/8/2019 ts 149-150

106. In relation to the issue of Dr Smith finding abdominal tenderness at 12.30 pm and not arranging Tahlia's transfer as a result, I note that:

    a. as Dr Smith pointed out, the tenderness was not a change in Tahlia's condition. She had presented initially with abdominal pain, Dr Pardhan found no tenderness but it was not long after she had been administered fentanyl, and Dr Kling had also found possible left iliac fossa discomfort on palpation;[138]

    b. the tenderness was mild, and Dr Smith found no guarding, rebound tenderness or other findings of concern;[139]

    c. when Dr Smith saw Tahlia, her observations, including her heart rate, were stable and she was displaying no pain;

    d. the PMH surgical team had advised that Tahlia could remain at Bunbury Hospital unless she deteriorated;

    e. Dr Pardhan, Dr Kling and Dr Graham had all examined Tahlia and were content for her to remain at Bunbury Hospital for observation; and that

    f. the X-ray and ultrasound scan showed no volvulus or intussusception.

107. It is also significant that, when Dr Graham examined Tahlia at 3.30 pm, he found slight tenderness, but he initially planned for her to stay at Bunbury Hospital over-night unless she had persisting vomiting or bile-stained vomit, in which case he would transfer her to PMH. It was only after she vomited a short time later that he called Dr Smith and they agreed to transfer her. Dr Graham's plan to keep Tahlia overnight showed that Dr Smith was not alone in considering that the tenderness he found in Tahlia's abdomen was not a significant change on its own.

108. As noted, Mr Williams understood that Tahlia's condition was critical at about 3.30 pm; however, Dr Kling stated that he told Mr Williams that Bunbury Hospital was aware that Tahlia's condition was 'serious or

[138] 19/2/2020 ts 82, 86-87
[139] 19/2/2020 ts 81

deteriorating' at that time. He did not think that he would have described her condition as 'critical' based on the notes.[140]

109. Importantly, Dr Cooke's findings of volvulus of the large intestine as the cause of death and the lack of bacterial infection or gangrene or ulceration in the gut underpin the following theory proposed by Dr Graham[141] and Dr Kling[142] separately, and accepted by Dr Blyth as possible.[143]

110. The theory suggests that Tahlia had presented at the Bunbury Hospital ED with a twisted bowel, but that it had spontaneously untwisted at around 6.00 am and her pain resolved. The twisting had bruised the bowel and caused the tenderness found by Dr Smith and Dr Graham. The twisting would have also caused some bacteria to get into the bloodstream, which led to the increased heart rate and possibly some other signs.[144]

111. Around the time that Tahlia arrived at the airport, her bowel became twisted again, caused the ongoing symptoms, including, I infer, 'third-spacing' and pooling of fluid in the abdomen and hypovolemia, and ended in her death.[145]

112. In the absence of any other explanation, I accept the foregoing theory as the most likely circumstances leading to Tahlia's death.

113. It is relatively easy in hindsight to say that there were signs and symptoms which, properly understood, indicated the underlying severity of Tahlia's condition. However, the evidence indicates that her condition was best seen as at risk of deterioration, and in foresight the signs did not point to an increasing risk until 4.00 pm. Even then, it was not unreasonable for the clinicians at Bunbury Hospital to consider that the relative stability of Tahlia's condition indicated that the risk was such that a transfer was not urgent. That turned out to be drastically wrong.

[140] Exhibit 10 17
[141] 5/8/2019 ts 34-35
[142] 19/2/2020 ts 52-54, 56
[143] 6/8/2019 ts 149-150
[144] 6/8/2019 ts 156
[145] 6/8/2019 ts 156

FAILURE TO PREPARE TAHLIA FOR TRANSFER

114. There was some confusion between Bunbury Hospital and the RFDS in relation to the arrangements for preparing and transferring Tahlia to Bunbury Airport. Some of the doctors at Bunbury Hospital expected the RFDS medical team to attend the hospital to prepare her and to accompany her to the airport with the SJA officers,[146] but Dr Enzor expected that a doctor from the hospital would have escorted her to the airport to provide a handover to him given how sick she was when he assessed her.[147]

115. The RFDS had a well-established practice of receiving a patient into its care at the relevant airport unless there were particular reasons for an RFDS team to go into a hospital to prepare the patient for flight. The RFDS had published a guideline with instructions to that effect since about 1991. The guideline available in 2015 (an updated 2011 version)[148] was sent to every hospital and other medical care provider in WA and was on the RFDS website.[149] The guideline could not be more clear in spelling out that, except in relation to complex unstable patients, the RFDS's expectation was for patients to be 'brought to and handed over at the airport.'[150] However, not all of the doctors at Bunbury Hospital were aware of even the existence of the guideline, let alone its contents.

116. Dr Kling said that the heads of department at Bunbury Hospital were not aware that the RFDS was not coming into the hospital to pick up patients until this incident with Tahlia.[151] Yet, the RFDS produced statistical data showing that, from the financial year of 2012-2013 to 2014-2015, the RDFS met over 90% of patients from Bunbury Hospital at the Bunbury Airport.[152]

[146] Exhibit 1.1.13; 5/8/2019 ts 14
[147] Exhibit 1.1.16 3; 5/8/2019 ts 71
[148] Exhibit 1.1.20 46
[149] 6/8/2019 ts 163
[150] Exhibit 1.1.20 20, 47
[151] 19/2/2020 ts 58-59
[152] Exhibit 12

117. The expectations of the doctors involved in Tahlia's care depended on their previous experiences. For example, Dr Jayasekera had expected an RFDS doctor or an SJA officer to attend the hospital to take a handover.[153] She had not been aware of the RFDS guideline.[154]

118. Dr Graham said that there was an apparent understanding that the point of transfer should be the airport, but he thought that it was an unsafe practice for paediatric patients.[155]

119. Dr Kling said that, from a surgical perspective where the patients they transferred were usually in the intensive care unit or in the theatre recovery area, his experience was that RFDS staff would come to the hospital to prepare the patient. The intravenous lines and the pumps are different, and handovers from anaesthetists are required.[156] He had not had much experience of transfers from wards.[157]At the time of Tahlia's admission, he was not aware of the RFDS guideline.[158]

120. Nurse Murphy said that nurses generally give a verbal handover to SJA staff and arrange patient transfer documentation. The nurses do not call the relevant doctor to do a handover.[159]

121. The SAC 1 review panel also concluded that medical staff at Bunbury Hospital were unaware that the RFDS teams did not routinely attend the hospital. The panel recommended that there should be a formalised guideline for transfers from Bunbury Hospital and that staff at regional hospital should be provided with information from RFDS.[160]

122. As to Dr Enzor's expectation of a doctor from Bunbury Hospital escorting Tahlia to the airport, that expectation was based on her dire condition when he assessed her. It is now clear that her condition was much more stable

[153] 5/8/2019 ts 14-15, 17
[154] 5/8/2019 ts 22
[155] 6/8/2019 ts 36-37
[156] 19/2/2020 ts 58-59
[157] 19/2/2020 ts 76
[158] 19/2/2020 ts 66
[159] 2/9/2019 ts 221-222
[160] Exhibit 1.2.33

when she left the hospital, so there would not have appeared to have been a need for a doctor to accompany her to the airport at the time.

123. The SAC 1 review panel considered that the treating medical staff at Bunbury Hospital should have reviewed Tahlia before she was transferred and should have reviewed the need for:

    a. ensuring the patency of the IV line,

    b. a nasogastric tube,

    c. blood tests, and

    d. antibiotic cover for infection.[161]

124. Dr Enzor raised the possibility that the IV line may not have been properly inserted in the first place when Nurse Wyeth was attempting to administer fluids to Tahlia on the aircraft.[162] However, Nurse Burns made clear that the IV line was functioning appropriately during the afternoon and evening on 1 October 2015. She said she checked it at 7.50 pm and recorded that there were no issues with it.[163] She wrote a contemporaneous note to that effect, and her evidence was supported by a fluid balance worksheet.[164]

125. The panel also appeared to suggest that Dr Enzor should have confirmed IV access before departing and should have inserted a nasogastric tube.[165] While there is no other expert evidence to counter the panel's view, Dr Blyth said that Dr Enzor was in a situation where he had to make an unenviable judgment call.[166]

[161] Exhibit 1.2.33 7
[162] 5/8/2019 ts 73-75
[163] 2/9/2019 ts 245
[164] Exhibit 1.1.27
[165] Exhibit 1.2.33 8
[166] 6/8/2019 ts 141

126. Dr Kling said that Dr Enzor made a judgment call that the best place for Tahlia was PMH, to have an operation as soon as possible, and Dr Kling could not fault that. He said that there was an option for Dr Enzor to have returned Tahlia to Bunbury Hospital for surgery, but he may have not been aware of that.[167]

127. In relation to the nasogastric tube specifically, Dr Enzor was not asked about inserting one, but Dr Pardhan said that it is difficult in a patient with Down syndrome and a tube can cause a patient to vomit and aspirate, which can lead to doing CPR.[168]

128. Dr Smith said that he and Dr Pardhan had discussed a nasogastric tube but had not made a definite diagnosis of bowel obstruction. Putting a tube in a child can be traumatic, it can encourage vomiting, and in a child with Down syndrome the upper airway and aerodigestive system can be much more difficult to negotiate, so they decided against it.[169] Dr Kling also said that placing a nasogastric tube in Tahlia would have been very traumatic for her on top of the risk of aspiration.[170]

129. It appears to me that the issue of inserting a nasogastric tube also involved a judgement call. In Dr Enzor's case, he had assessed Tahlia as being in septic shock, for which the treatment was resuscitation fluids, antibiotics and source control, so the insertion of a nasogastric tube did not appear to be part of his considerations. His priorities were to get the IV line working and to transport Tahlia to PMH for an operation.[171]

130. As to the panel's last two recommendations, it is clear that a blood test and antibiotic cover did not occur prior to Tahlia's transfer, but the SAC 1 review panel did not explain why the doctors at Bunbury Hospital should have identified the need for either of them. In any event, Tahlia's temperature was normal and stable until she had left Bunbury Hospital, so I infer that antibiotics were not administered because an infection was probably not suspected.

[167] 19/2/2020 ts 74
[168] 19/2/2020 ts 44
[169] 19/2/2020 ts 84
[170] 19/2/2020 ts 55
[171] 5/8/19 ts 72-73

131. In the light of the foregoing, I am satisfied that the arrangements for Tahlia's transfer were reasonable in the circumstances known to staff at Bunbury Hospital at the time that the SJA officers picked her up.

132. I am also satisfied that Dr Enzor's actions in managing Tahlia were reasonable given her presentation and the exigencies he faced.

LACK OF ONGOING MEDICAL REVIEWS

133. As noted, after Dr Graham reviewed Tahlia following her vomit at 4.00 pm, no doctor reviewed her again at Bunbury Hospital, and the standard four-hourly observations were maintained.

134. Tahlia was seen by Nurse Burns every hour to check her IV line hourly and to record the quantity of fluid delivered to her.[172] Nurse Burns said that she observed Tahlia physically when she checked the IV line and that, if she had been concerned by Tahlia's status for any reason or if Tahlia's observations had gone out of range, it would have escalated her care. She took observations at 3.40 pm and 6.55 pm, and they were reassuring.[173]

135. Dr Blyth said that nursing observations were the key to monitoring patient stability.[174] He said that, if a child is unwell enough to be transferred to a tertiary facility, he would normally expect more frequent observations during the time before the transfer. He accepted that observations every four hours is the standard, but he said that you need a flexible approach to observations or you will miss things.[175]

136. Dr Kling also thought that more frequent observations would have been indicated after 4.00 pm on 1 October 2015, and closer medical review was probably indicated during that time as well.[176]

[172] Exhibit 7 3
[173] Exhibit 7 4
[174] 6/8/2019 ts 144
[175] 6/8/2019 ts 128
[176] 19/2/2020 ts 62-63

137. The evidence of Dr Blyth and Dr Kling indicates that more frequent observations and medical reviews of Tahlia would have been appropriate. From a common sense perspective and in line with Dr Blyth's opinion, the fact that Tahlia was being transferred to PMH to observe her because the clinicians at Bunbury Hospital did not have a clear diagnosis of her problem is a strong argument that they should have been monitoring her more closely.

138. That is not to say, however, that close monitoring would have been more likely to have led to a different outcome. The evidence as I understand it indicates that, until Tahlia's sudden deterioration at Bunbury Airport, more frequent observations may not have revealed any signs of a pending emergency.

139. Related to the issue of medical reviews, Dr Blyth and Dr Kling both thought that further investigations could have been done during the day, but neither expressed a strong view.

140. Dr Blyth said in his report that the early blood tests at Bunbury Hospital showed a lactate level that was evidence of compensated lactate acidosis.[177] He said in oral evidence that, after 4.00 pm, he would have wanted to feel Tahlia's abdomen and to check her perfusion. While he did not consider it necessary, a urinary catheter could have been used to see if she was producing urine and blood tests could have been repeated, including for lactate to see what was happening with her serum lactate.[178]

141. Dr Kling said that the lactate acid level in the initial blood test results was elevated, but it was not lactate acidosis.[179] However, he said that he might have repeated the lactate test in the 1.30 pm blood tests.[180] He said that he would not have repeated the ultrasound scan.[181]

[177] Exhibit 1.2.29 2
[178] 6/8/2019 ts 157
[179] 19/2/20 ts 52
[180] 19/2/20 ts 54
[181] 19/2/20 ts 54

142. Similar to more frequent observations and medical reviews, the fact that the clinicians at Bunbury Hospital were concerned that they did not have a clear diagnosis of the cause of Tahlia's condition seems a good reason for them to have also continued with further investigations, such as blood tests, X-rays and scans.

143. Ironically, however, it is not clear whether such investigations would have likely altered the outcome because we do not know in their absence whether they would have indicated that Tahlia was deteriorating.

CHANGES SINCE TAHLIA'S DEATH

144. Ms Winsor described how, following Tahlia's death, WACHS implemented a number of changes to its systems. Some of those changes were made as a result of her death, and some were systemic issues which may have assisted in her care if they had been in place in 2015.

Memorandum of Understanding

145. In December 2015, the heads of the departments of surgery (Dr Kling) and paediatrics (Dr Stephens) at Bunbury Hospital entered a memorandum of understanding (MOU) to formalise a process by which the two departments would collaborate and provide support when a patient presents with undiagnosed abdominal pain. The intent of the MOU is to streamline the process of requesting second opinions about paediatric patients and paediatric surgical patients, to encourage joint paediatric/surgical admissions, and to facilitate liaison with paediatric tertiary facilities.[182]

146. Attached to the MOU are a clinical practice guideline for causes of abdominal pain in children, a constipation pathway and a paediatric abdominal pain pathway flowchart.[183]

[182] Exhibits 1.2.34; 1.2.34.1
[183]

Agreements with Perth Children's Hospital

147. Perth Children's Hospital has agreed in principle to accept patients from Bunbury Hospital with undiagnosed abdominal pain which may lead to better communication and earlier transfers of children.[184]

148. In Tahlia's case, it is not clear that she would have been transferred to PMH earlier if a similar agreement had been in place.[185] The fact that PMH had readily agreed to accept her transfer when Dr Pardhan spoke to the surgical registrar at 10.30 am on 1 October 2015 suggests not.

Escalation Project

149. This project was aimed at a number of initiatives, including developing a more sensitive observation chart, which I understand to be the Parrot chart, and setting triggers for escalation of care that involved nurse/doctor and family concerns. At the time Ms Winsor gave evidence, the Parrot chart was in a trial phase.[186]

150. There was also paediatric sepsis pathway that had been drafted and tabled at a paediatric/neonatal forum but had yet to be endorsed. [187] That pathway assists in recognising, responding and escalating treatment of sepsis in children.[188] However, as Dr Blyth said, a sepsis pathway would not likely have changed the outcome of Tahlia's case because, if she triggered the pathway, she would have been reviewed by senior clinicians, and that had occurred in any event.[189]

Recognising and Responding to Clinical Deterioration Policy

151. On 30 September 2016, the Department of Health published a guideline to establish a set of minimum mandatory requirements on health service providers through the development of local policies to facilitate the early recognition and response to acute deterioration of all inpatients across the

[184] Exhibit 1.2.34; ts 184
[185] 6/8/2019 ts 184
[186] 6/8/2019 ts 185
[187] Exhibit 1.2.34
[188] Exhibit 1.2.34.2
[189] Exhibit 1.2.29 6

WA public health system. There is also a national 'recognising and responding to acute clinical deterioration' standard for which WACHS-SW was accredited in 2019.[190]

152. Ms Winsor suggested that Tahlia's deteriorating clinical condition may have been identified had the policy been implemented by 2015, but she said that the policy requires the use of colour-coded observation charts.[191] She did not explain why such charts would have been much different from the charts used in Bunbury Hospital at the time.

153. Ms Winsor also said that a paediatrics unit nurse manager has been recruited, which has made a huge difference to the unit and its development given the increase in population and increasing specialisations.[192]

Executive on Call and Care and Respond Early Call (Care Call)

154. Executive on Call, which is an escalation pathway to an executive member, was established in WACHS-SW in February 2016 in order to provide any staff member who had a concern about a patient to contact service managers, who could request medical or nurse directors to instruct clinical staff to review the patient.[193]

155. Ms Winsor said that the process was established in other WACHS regions and that it works very well. Its use had increased as staff were escalating their concerns.[194]

156. I note that, even in 2015, nurses at Bunbury Hospital were able to escalate their concerns to the acting clinical nurse manager and, in her absence, the hospital resource coordinator. Nurse Murphy and Nurse Berryman were concerned about Tahlia's admission to the paediatric ward because patients with bowel obstructions, which they apparently believed Tahlia had, were not accepted at the ward. Such patients went to PMH instead. Nurse Murphy called the hospital resource coordinator, who advised her not to

[190] Exhibit 1.2.34.3
[191] Exhibit 1.2.34
[192] 6/8/2019 ts 193
[193] Exhibit 1.2.34
[194] 6/8/2019 ts 198

question the doctors' decisions. Once the nurses were aware that the doctors were happy to admit Tahlia to the ward, they allocated a bed for her.[195]

157. Care Call is an in-hospital process for family or friends of a patient to call an on-call operations manager if they are concerned about the management of the patient. Ms Winsor said that the process has provided benefits to families and to the hospital.[196]

158. However, Mrs Bembridge made the point that, when doctors asked about what was to be done with Tahlia, she always answered by saying, 'Whatever you think is best.' She said that she put her trust in them and did not question their judgment.[197]

159. Mr Williams said that it was nice to have a hotline, but the public assumes that doctors and nurses in the hospital environment are the professionals. He wondered how many people would actually ring the hotline if a doctor or a nurse told them that the patient was okay.[198]

Inter-hospital transfer initiatives

160. Potentially of more direct relevance to Tahlia's case has been the implementation of a number of changes to the transfer transport option from Bunbury to Perth hospitals.

161. The most dramatic change in terms of infrastructure has been the access to a Department of Fire and Emergency Services helicopter that is based in Bunbury. There are now the options of SJA road ambulance, the RFDS and a helicopter. [199] However, it is important to note that the three different modes of transport each have their own benefits and detriments. For example, helicopters can be quicker than road transport, but they are

[195] Exhibit 5
[196] 6/8/2019 ts 188
[197] 19/2/20 ts 117
[198] 19/2/20 ts 12
[199] 6/8/19 ts 189, 196

expensive, noisy, and not pressurised, and only limited procedures can been done to a patient once they are in the air.[200]

162. As to SJA's exclusive contract with WACHS for an ambulance service in regional WA, Ms Winsor said that the WACHS chief executive has requested that the Bunbury region be released from the requirement to use SJA so that other ambulance providers could be used. She said that the process was then in train.[201]

163. Ms Winsor also noted that WACHS-SW and SJA regional management have established quarterly meetings, which included discussion on near-miss or clinical incidents to review and improve the service. In addition, the respective managers have direct access to each other's senior managers to enable and support escalation when required. As of July 2019, all events involving escalation were resolved or addressed.[202]

164. In addition, in September 2018, WACHS published the Country Ambulance Strategy with the intention to set the foundation to further support and build the inter-hospital transport service in country WA.[203] The strategy had been the subject of public consultation over 11 months and was endorsed in principle by the WACHS Board in February 2018. It contains 19 recommendations and expresses the expectation that the Department of Health, WACHS and SJA will implement it immediately.[204] The evidence in the inquest did not extend to any details of any implementation of that strategy.

165. Also planned to be in operation in 2020 is an inter-hospital acute patient transfer coordination function in the Command Centre, which is currently a 24-hour emergency and inpatient telehealth service providing support to doctors and nurses in regional WA.[205] According to the WACHS website, the acute patient transport coordination function will oversee safe, timely and efficient patient transport to and from regional and metropolitan

[200] 6/8/19 ts 166
[201] 6/8/19 ts 196
[202] Exhibit 1.2.34.1 7
[203] Exhibit 1.2.34
[204] Exhibit 1.2.34.8
[205] 6/8/19 ts 189;

hospitals for admitted country patients.[206] It is not clear that the Command Centre could have affected Tahlia's transfer to PMH had the acute patient transfer coordination function been in operation in 2015, but it does appear to be a welcome initiative.

166. In relation to clinical guidelines and policies for inter-hospital transfers, in 2016 WACHS-SW developed an inter-hospital transfer flowchart. The flowchart provides clinical guidance on establishing the ideal transport mode depending on urgency and the type of continued care required for the patient. On 21 September 2017, WACHS updated that flowchart with the 'Assessment and Management of Interhospital Transfers Policy' (Transfers Policy) which provides for a selection of helicopter, RFDS, ambulance or patient transport vehicle depending on the urgency and the destination.[207]

167. When the Transfers Policy is applied to Tahlia's known circumstances at 4.00 pm on 1 October 2015, her case would have been identified as 'Urgent' since she was stabilised but she had a risk of deterioration.[208] Assuming that to be correct, the ideal time frame within the Urgent category was three to six hours by ambulance or air, so it appears that the amount of time her transfer would take under the Transfers Policy may not be much different than it was in 2015. On that basis, it appears that the crucial determinant remains the recognition of the clinical urgency of the patient. As Ms Winsor said, 'the first step is determining … how sick the patient is and having a really good understanding of that before you go looking for the transport.'[209]

168. A recommendation from the SAC 1 review panel was the establishment of a paediatric retrieval service based on the NETS[210] (which works in conjunction with SJA, the RFDS and Medical Air to provide neonatal intensive care during transport). Dr Kling supports the concept, [211] but Dr Yaman said that the RFDS could have responded as quickly as a

[206] http://www.wacountry.health.wa.gov.au/index.php?id=commandcentre
[207] Exhibit 1.2.34.7
[208] Exhibit 1.2.34.7
[209] 6/8/19 ts 191
[210] Exhibit 1.2.33 6
[211] 19/2/20 ts 61, 110

paediatric retrieval service and that the RFDS doctors include retrieval consultants who have specialised in retrievals.[212]

169. More pointedly, Professor Langford said that the SAC 1 recommendation with respect to a paediatric retrieval service was naïve and ill-informed. He said that the RFDS already provides a paediatric retrieval service across WA for over 1000 patients a year. In terms of transporting critically ill infants, only 10 ICU-level ventilated babies over the age of four weeks were transported during a year, and only three of those were in the south of the State. Professor Langford also reiterated Dr Yaman's point that the RFDS staff were experts in retrieving patients and were best able to manage paediatric transfer in WA.[213]

170. Professor Langford said that he agreed with Dr Graham's frustration with not being able to move patients as quickly as he would like, but it was a matter of funding and resources.[214] He said that, rather than investing in a new paediatric retrieval service, he would rather that the existing service be funded properly.[215]

171. Professor Langford also mentioned that, in 2012 the RFDS had put up a proposal for an intensive care road ambulance to be located at Jandakot Airport to service the southwest. It would have provided a quicker, less expensive service to Bunbury than an aircraft, but the proposal was not accepted. He tried again in 2016/2017 to establish the road retrieval service, but it did not go forward.[216]

172. Ms Winsor had no direct knowledge of the RFDS proposal for an intensive care road ambulance.[217] Dr Lakshminarayanan's statement notes that, as of August 2019, a paediatric retrieval service had not been implemented and will probably not be implemented for a few years given the likely cost.[218]

[212] 5/8/19 ts 112
[213] 6/8/19 ts 163-164
[214] 6/8/19 ts 164
[215] 6/8/19 ts 178
[216] 6/8/19 ts 164-165
[217] 6/8/19 ts 197
[218] Exhibit 4 2

173. In my view, even taking into account the possibility that Professor Langford and Dr Yaman may be biased in favour of the RFDS to some degree in their assessments of the best way forward for a paediatric retrieval service in WA, their arguments seem reasonable and should be seriously considered by the Department of Health.

COMMENTS ON THE CARE PROVIDED TO TAHLIA

174. In hindsight, it is almost always possible to identify shortcomings in circumstances that end tragically. For example, Dr Smith said that he did not think that he had acted unreasonably or that he had missed any obvious signs in Tahlia's presentation, but with the benefit of hindsight, he felt that it would have been preferable for him to have transferred her to PMH as soon as he saw her on 1 October 2015.[219]

175. Of course, coroners do have the benefit of hindsight, but it must be used with a consideration of what was reasonable in the circumstances and by reference to the standards that applied at the time.

176. An overview of the evidence establishes that the significant aspects of Tahlia's care at Bunbury Hospital were:

    a. upon Tahlia's presentation, she was stabilised and her symptoms were treated successfully;

    b. the clinicians who managed her were aware of her history of surgically treated twisted bowel;

    c. the appropriate approach was to monitor her, and that was done;

    d. appropriate investigations and tests were performed;

    e. the results of the investigations excluded acute bowel obstruction;

    f. Tahlia's care was escalated to senior clinicians; namely, a consultant paediatrician, a consultant surgeon and the head of surgery;

[219] 19/2/20 ts 96

g. the PMH surgery team was consulted, and their advice was to monitor Tahlia and to transfer her if she deteriorated;

h. apart from an increased heart rate from about 3.40 pm, Tahlia's vital signs were stable and there was no substantial change to findings on examination;

i. when a sign of potential deterioration was displayed at about 4.00 pm, a transfer to PMH was arranged;

j. after a determination was made to transfer Tahlia to PMH, she was seen by a registered nurse every hour and was administered IV fluids;

k. until Tahlia was collected by SJA officers, her vital signs were relatively stable and she showed no significant indication of having a re-twisted bowel; and

l. after SJA officers had collected her to take her to the airport, her vital signs were still stable.

177. On the basis of those factors, I am satisfied that the care Tahlia received at Bunbury Hospital was reasonable in the circumstances.

178. It is not surprising that the clinicians who managed her did not foresee that she would develop a re-twisted bowel when she did. The fundamental problem facing them was that they were unable to diagnose the cause of her illness because it was intermittent. I infer that, even if they had arranged for more X-rays or ultrasound scans, a twisted bowel would not have been seen.

179. On that basis, it is unclear on the evidence what would have occurred if Tahlia had been transferred to PMH earlier on 1 October 2015. If she was stable when she arrived there, she would likely have been admitted for observation. The same risk of deterioration from an unknown source would have been present, but a deterioration could have been addressed without delay. However, if Tahlia had deteriorated suddenly at Bunbury Airport, or SJA vehicle in the course of an earlier transfer, it is possible that the outcome would have been the same.

180. As to SJA and RFDS, I am also satisfied that the care provided to Tahlia by the SJA crew and the RFDS crew and the clinicians at Jandakot Airport was reasonable in the circumstances.

181. To the extent that it might be argued that Dr Enzor should have returned to Bunbury Hospital when it became apparent that Tahlia was very unwell, I accept that his decision was a judgment call. Given the logistical problems that would have confronted him at Bunbury Airport had he returned for surgical intervention, including the lack of a specialist anaesthetist and the lack of an intensive care unit, his decision appears to have been justified.

182. I have no trouble accepting Dr Kling's evidence that he would have been capable of emergency surgery to treat Tahlia, but Dr Enzor could not have been expected to have known that. Even Dr Smith considered that the anaesthetists in Bunbury were unlikely to be able to manage a Down syndrome case like Tahlia's,[220] and Dr Graham said that the only place where surgical intervention could occur safely would be PMH.[221]

183. As to the standard of medical care provided to Tahlia at PMH, there is no evidence to suggest that it was other than exemplary.

CONCLUSION

184. This inquest into Tahlia's death revealed a number of significant issues and, no doubt, gave some impetus to improvements to our health system. To that extent, Tahlia's family can take some solace from the fact that her death may have led to changes that have reduced the likelihood of another child dying in similar circumstances in the future.

185. There is no doubt that Tahlia was cared for by nurses and clinicians who were experienced and highly qualified in their respective specialities. That they were unable to save Tahlia was due to the difficult nature of her condition rather than a lack of care on their part. Indeed, it is a measure of

[220] 19/2/20 ts 12
[221] 5/8/19 ts 42

their dedication and commitment that they remain affected by the tragedy of Tahlia's untimely death.

B P King
Deputy State Coroner
1 December 2020