AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

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Inquiry under Part 14 of the Health Services Act 2016 (WA)

Independent Inquiry into Perth Children's Hospital (PCH)

November 2021

Contents

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1. Executive Summary

1.1 On Saturday 3 April 2021, at 1733 hrs a 7-year-old girl with a short history of illness, Aishwarya Aswath, was brought to the Emergency Department (ED) at Perth Children's Hospital (PCH) by her parents, Aswath Chavittupara and Prasitha Sasidharan. Aishwarya's care, her extremely rapid deterioration in the ED and her tragic death has resulted in immense loss, anguish and pain suffered by the family.

1.2 The Coroner's Court of Western Australia has since confirmed, in correspondence with the family, the cause of Aishwarya's death as "multiorgan failure due to fulminant sepsis (streptococcus pyogenes)".

1.3 Sepsis is a time-critical medical emergency that arises when the body's response to an infection damages its own tissues and organs leading to failure of multiple organs, and death if not recognised and not treated promptly. Sepsis can occur in response to various types of infections, including bacterial, viral or fungal infections which are acquired both in community and healthcare settings. Deterioration from sepsis can be rapid and unpredictable, particularly in children. It can also be difficult to identify, as symptoms of sepsis can be common to many other, less consequential, conditions. The Australian Commission on Safety and Quality in Health Care (the Commission) is undertaking a program of work to improve early recognition, treatment, outcomes and post-discharge support for people at risk of or diagnosed with sepsis in Australia. After a national collaborative venture proved unsuccessful in 2017, PCH had developed a local sepsis guideline and, more recently, was working on a pathway and enhanced trigger tool.

1.4 Every day, health care professionals practise their skill and knowledge within excessively complex situations and meet unexpected patient outcomes. The Inquiry team interviewed many such professionals, who were profoundly distressed by the death of Aishwarya, and the unimaginable loss being experienced by her parents.

1.5 The death of Aishwarya required the hospital to conduct a Root Cause Analysis (RCA) as a means of investigating the circumstances surrounding her death and to identify any opportunities to improve care and care outcomes in the future. Following the report of the RCA, the Director General of the Western Australian Department of Health (the Department) convened an Independent Inquiry into PCH (the Inquiry). The establishment of the Inquiry was a recommendation of the RCA, providing an opportunity to examine in broader perspective, the factors which may have contributed to Aishwarya's death in the ED, and more generally the approach to clinical governance, risk, adverse incidents and the culture of consumer service at PCH.

1.6 Members of the Inquiry team met with Aishwarya's parents, Aswath Chavittupara and Prasitha Sasidharan, along with the advocate and support person, Suresh Rajan, by videoconferencing on six occasions. It was, disappointingly, not possible to meet in person due to the lockdowns and travel restrictions associated with the Delta strain wave of the COVID-19 pandemic. This reality and substantial obstacle was discussed and acknowledged in family interactions. The meetings provided an opportunity to listen to and learn from the family's distress, concerns and specific complaints; to share the intent, commitment and progress of the Inquiry; and to provide timely feedback regarding emerging findings in principle.

1.7 The parents and support person shared a number of concerns, perceptions and strongly felt sentiments. There remained a deep sense of disbelief: "how could trained professionals have missed the warning signs of such serious illness". The family wished the Inquiry Report to indicate their unresolved disagreements concerning some aspects

of the conduct, record, findings and acceptance of the RCA, along with persistent feelings of distrust in the system.

1.8   After the death of Aishwarya, open disclosure and communication with her family had proven difficult. The PCH executive and clinicians were limited in their intended pursuit of disclosure, explanation and support. Aishwarya's parents have provided a number of reasons behind their decision not to engage with the hospital. These relate to a loss of trust in the hospital and their belief that some of information it provided was incorrect. Unfortunately, this breakdown in trust exacerbated the family's grief and, among other outcomes, hindered the hospital delivering the support and information it would otherwise have provided the family.

1.9   There is an opportunity for the hospital to advance the open disclosure process, to regain the trust of the family and to engage them in their commitment of honouring Aishwarya's memory through sustained reform and performance. Following this tragic death and the challenging environment both before and after the event, there is also much healing to be pursued within the hospital, bringing everyone closer and repairing historic divisions. The Inquiry found a highly dedicated hospital staff, devastated by the tragedy and committed to continuing improvement in the care of all children.

1.10   The Inquiry team examined relevant records and documents associated with Aishwarya's death, including the RCA report; organisational history and relationships; clinical governance policies and procedures operating within the hospital; operational performance; staffing numbers; education and training; and organisational culture.

1.11   A series of virtual interviews were held with the hospital's management/executive, Board (past and present), and clinical staff, as well as consumers and the RCA panel. The Inquiry team found a number of contextual factors may have contributed to the ED environment, safety and effectiveness on the day of Aishwarya's death, for example:
   • Since the relocation of services from Princess Margaret Hospital (PMH) to PCH, the larger, reconfigured ED proved more challenging to staff and manage.
   • The triage and waiting areas were particularly vulnerable and suboptimally staffed.
   • The hospital's historic staffing and recruitment strategies, particularly for nursing staff, were severely disrupted by the pandemic related border closures and staff movements to state-wide COVID-19 activities.
   • A major increase in ED presentations and other service demands, in late 2020, due to unseasonal respiratory illnesses and increases in adolescent mental health patients, was not able to be met with an organisational response of sufficient urgency.
   • The historically problematic access block became worse.
   • ED staff were described as exhausted, demoralised and relatively isolated.
   • Staffing and rostering challenges, along with the inability to backfill higher than usual sick leave, may have further contributed to workload pressures in the ED.
   • Parental communication and escalation supports were described as insufficient.
   • Sepsis recognition/management pathways and related observation tools were challenging.
   • Other factors that may have contributed include gaps in clinical supervision models; PCH-wide meaningful consumer partnerships; and embedded education and training programs relating to each of the above factors.

1.12   The RCA addressed a number of these factors, along with a highly rigorous analysis of the clinical details of Aishwarya's care. The Inquiry team noted that the RCA process itself was unusual and highly challenging. The extraordinary handling of the report, most notably the absence of Executive team endorsement, along with the later referrals of staff to the Australian Health Practitioner Regulation Agency (Ahpra), the unexpected release to the media and the public scrutiny, did much to damage trust and morale at

PCH. The CE, in consultation with his Executive team, did not endorse the RCA report but accepted the recommendations and proceeded to establish a comprehensive process to implement and monitor all the RCA recommendations along with the ANF 10-point Plan. Staffing establishments were increased and resources were rapidly mobilised, further supplemented by budgetary enhancements.

1.13 Child health is an essential cornerstone of our society. It is more than the absence of disease and involves more than providing health care. Child health is shaped by multiple determinants including early childhood health, development and education. Investing in these areas is a community responsibility and a communal investment. In Western Australia, PCH is the sole specialist paediatric facility and an essential leader in children's healthcare across the state. The recent budgetary enhancements and commitments are applauded. They must be followed by ongoing evaluation, review and resourcing to ensure a sustainable trajectory of service and leadership in the safe, effective and compassionate care of children.

Key findings

The findings and recommendations of this investigation are arranged by the Terms of Reference.

Any matters raised by the Aswath family in relation to the care and treatment of their daughter

1.14 Aishwarya's care, her extremely rapid deterioration in the ED and her tragic death has resulted in immense loss, anguish and pain suffered by Aishwarya's family and constitutes a personal crisis of unimaginable proportions.

1.15 Group A Streptococcus (GAS) bacteria were identified in Aishwarya's blood film and subsequently cultured from her blood and other body tissues. The Coroner's Court of Western Australia has since confirmed, by correspondence to the family, the cause of Aishwarya's death as "multiorgan failure due to fulminant sepsis (streptococcus pyogenes)".

1.16 Members of the Inquiry team met with Aishwarya's parents, Aswath Chavittupara and Prasitha Sasidharan, along with the advocate and support person, Suresh Rajan, by videoconferencing on six occasions. The family and the advocate shared a number of concerns, perceptions and strongly felt sentiments. They expressed anguish, anger and disbelief. Urgency, communication and compassion were felt to have been inadequate.

1.17 The family were troubled and unconvinced about the RCA conduct, record and findings, as well as the subsequent process of acceptance without endorsement. They wished the Inquiry Report to indicate their points of disagreement with the RCA and their level of distrust in the system.

1.18 Through the anguish of loss and despair, Aishwarya's parents became increasingly committed to honour the memory and legacy of Aishwarya by seeking to create an improved healthcare system for children.

The conduct of the RCA, and issues identified by the RCA, and the recommendations made on the basis of those findings

1.19 The death of Aishwarya required the hospital to conduct an RCA. The Inquiry team found the conduct of the RCA by the panel to have been robust and diligent, with a highly rigorous examination of the factors that may have contributed to this tragic death.

1.20   After the death of Aishwarya, open disclosure and communication with her family proved difficult. Unfortunately, this breakdown in trust exacerbated the family's grief and, among other outcomes, hindered PCH in delivering the support and information it would otherwise have provided the family.

1.21   Receiving the full RCA report without explanation of some matters has added to the concerns of Aishwarya's parents and has not assisted their understanding of the tragic death of their daughter or helped their relationship with PCH. In analysing the report, the family identified discrepancies in some descriptions and specific timelines on the record as distinct from their recollection.

1.22   The Inquiry team formed the view that the RCA recommendations were relevant and appropriate. Their implementation is essential to ensure patient safety within the ED. The hospital has described and put in place a comprehensive enactment process to manage the implementation of the recommendations.

The ED's staffing, patient flow model, clinical supervision and education programs (as recommended in the RCA)

1.23   The history of Princes Margaret Hospital/Perth Children's Hospital has been challenging. Since 2018, there has been a gradual trajectory of improvement in morale, cohesion and engagement. The relocation from PMH to PCH, albeit troubled and delayed, created a new, more spacious and attractive patient care environment.

1.24   The ED was designed to be substantially bigger, including enhanced triage capability and dedicated waiting areas. The commissioning process signed off on appropriate staffing and operational procedures. However, with experience, the new design proved more challenging to staff and manage. The location of the new ED also added a sense of physical isolation.

1.25   The hospital's historic staffing and recruitment strategies, particularly for nursing staff, had relied heavily on national and international recruitment. There was also a disproportionate dependence on casual and temporary contract arrangements. With the emergence of the pandemic, nursing numbers and recruitment options were severely disrupted by both border closures and staff movements to state-wide COVID-19 activities. Further, more demanding clinical practice processes and sick leave thresholds arose from COVID-19 related protocols.

1.26   The pressure on the ED due to the significant unseasonal rise in presentations, from October to December 2020, was not able to be met with a response of sufficient urgency and scale. A further contributing factor was the suboptimal level of contingency resourcing and capacity to respond to unexpected surges in demand.

1.27   Junior medical staff reported both challenges and improvements in measures to better support their wellbeing. The training programs and clinical supervision were satisfactory but the inevitable impediments to regular attendance, due to surges in workload, were identified. Importantly, reduced access to leave has affected staff wellbeing.

1.28   The Recommendations of the RCA, along with the ANF 10-point Plan, address the matters identified above. A substantial number of staffing enhancements (in the ED and other clinical departments) are being implemented in a staged fashion, with particular emphasis on nursing positions. The addition of nursing personnel in triage and the waiting areas, along with enhanced and improved protocols, have been progressed with urgency. The comprehensive implementation plan will require continuing monitoring and investment to ensure sustainable progress.

The culture of customer service within the ED in relation to children and their families particularly those of culturally and linguistically diverse (CALD) background

1.29   Documents submitted to the Inquiry described a range of consumer surveys, feedback opportunities and complaint mechanisms. While there was evidence to demonstrate courteous and timely correspondence in reply, there was less information to indicate further actions to explore or progress the content of such exchanges. The consumer comments were mixed, as exemplified by praise for the new physical environment at PCH but concerns regarding staffing and communication, including the ED.

1.30   The data regarding families of CALD background is not well documented and monitored across the system. The challenge begins with limited mechanisms of identifying such patients in medical records or survey responses. There was also acknowledgment of gaps in cultural competency training and skills.

1.31   Consumers interviewed recognised that PCH had included them in aspects of governance that were visible and formal. However, there were strong views expressed that it's translation into meaningful engagement and partnership was lacking. Consumers did not feel included in the process of agenda setting, of planning, of co-design and of relevant decision making.

1.32   Perceptions that the responses to the tragedy were defensive rather than forward looking were raised by consumer representatives. They feared a missed opportunity to embrace change and improve culture. There was widespread enthusiasm to be invited into the process and to contribute more effectively. The implementation of the RCA recommendations was warmly welcomed, with particular emphasis on staffing enhancements and the rollout of the CARE Call system in ED.

1.33   In children's healthcare the role of the families as partners in care is paramount. Central to this partnership is the parental role in recognising changes in their child's behaviour, responsiveness or health status. It is an essential component of paediatric clinical care to "listen to the parent" and to appreciate the unique role of the parent in recognising early signs of illness or deterioration. Aishwarya's CARE Call, aptly named in the memory of a child whose tragic death has inspired so much soul-searching, reform and improvement, aligns well with these principles.

Roles and responsibilities of clinicians, management and the executive at PCH, and their escalation of issues to the Child and Adolescent Health Service Board

1.34   Emerging from a challenging history, PCH was on a path of gradual improvement in morale, cohesion and engagement. That progress was severely tested by a range of COVID-19 related challenges, especially the unseasonal increases in ED presentations from late 2020 and then markedly set-back by the circumstances surrounding the tragic death of Aishwarya.

1.35   The Child and Adolescent Health Service (CAHS) Board has supported this Inquiry through a range of documents and records, followed by discussions, which included input from some former Board members. There was a strong sense of commitment, engagement, knowledge and understanding of the issues, with emphasis on learning and moving forward. The working relationship between the Board and Executive team appeared tested at times but was managing well in difficult circumstances. The secondment of the CE, the number of staff in acting positions and the relative inexperience of some senior executives were considered to be impediments to effective governance.

1.36 Increased PED activity trends were reported nationally in late 2020. The challenges at PCH appeared disproportionate, based on both staffing availability and activity volume. There were well documented escalations of concern, encompassing middle management, CAHS Executive team, the Board and the Department, as appropriate. A key finding of this Inquiry is an understanding of the multiple factors and impediments that led to a response deemed insufficient in scale and timeliness.

1.37 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 RCA report and referrals of clinical staff to Ahpra.

PCH's clinical incident management process, including an assessment of previous SAC1 incidents to identify potentially preventable factors

1.38 PCH and CAHS have a range of policies to guide and describe clinical incident management processes.

1.39 Communication of outcomes, reporting and responding to the findings of clinical review processes appeared to be quite varied within PCH. A range of communication and implementation mechanisms and strategies were identified, but there appeared to be a diversity of approaches that were not always integrated and coordinated. PCH may benefit from a clear safety and quality framework for reporting and responding to clinical review processes.

1.40 There appear to be some limitations to the current model for the PCH Mortality and Morbidity Review Committee. Interviewees described a single hospital-wide committee that only reviews mortality (not morbidity), possesses limited levers for implementation of committee recommendations, and appeared variably connected to other safety and quality improvement processes.

1.41 Between 1 January 2020 and 3 April 2021, there were 24 RCA reviews of SAC1 incidents. Of these, nine involved sepsis or healthcare associated infection, and three of those occurred within the ED, none of whom died. The first two of those cases involved delayed identification of sepsis, in the third case, sepsis appeared to have been appropriately identified and managed.

PCH's clinical risk management process

1.42 The Department of Health has developed and implemented a comprehensive safety system which aims to protect the people of Western Australia from harm related to healthcare. As part of its safety program, the Department of Health has published Clinical Risk Management Guidelines which provide guidance to health service providers.

1.43 PCH and CAHS have a policy framework for risk management, with a focus on identification, prevention and mitigation of organisational risks.

1.44 PCH does not appear to have a separate policy or guideline on clinical risk management, and the overarching CAHS Risk Management Policy has limited reference to clinical risk. PCH should implement the Department of Health's Clinical Risk Management Guidelines.

1.45 It is unclear, from documentation and comments from interviewees, what the most relevant and appropriate pathways are for staff wishing to raise and/or escalate concerns about clinical risks, and to support consideration of these risks at an organisational level.

The performance of PCH in relation to safety and quality measures as compared to national peers

1.46 Benchmarking against various state and national cohorts is well established at PCH. A key benchmarking peer group for children's hospitals is a cohort of comparable tertiary paediatric facilities in other jurisdictions. CHA provides that platform and has documented that national trends in activity across the peer group of six paediatric emergency departments (PEDs) in children's hospitals have been relatively consistent and well aligned over the years.

1.47 PCH has often performed better than peers in the measures of ED waiting times, of ED average length of stay (ALOS), and of ED admission rates. Much of this reflects the historic WA leadership in the introduction, emphasis and monitoring of the "4-hour rule" (2009) and the defined WA Emergency Access Target (WEAT, January 2016) performance for ED's.

1.48 The CHA activity reports reflect relatively consistent patterns of reductions in ED presentations across all peer group facilities in the second quarter of 2020 compared with the same quarter of 2019, and then a sharp and sustained rise in presentations until mid-2021. Directors of PED's across all children's hospitals have expressed their consensus warnings regarding the risks associated with the activity patterns, the staffing pressures and the inadequacy of contingency responses, with particular emphasis on ED waiting rooms.

1.49 The PCH trends have mirrored and often exceed the national patterns. During the last quarter of 2020, the PCH ED transiently became the single busiest PED in the nation. Of particular note, CHA data indicate that PCH has shown the highest numbers of "PED presentations per nursing FTE" for the entire cohort, over the past two years. With the extraordinary rise in activity in late 2020, the gap in relative nursing workforce between PCH and other benchmarking peers had further widened.

1.50 The WA Government made significant investments in hospitals, health and mental health services with a $1.9 billion boost in the 2021-22 State Budget to help address the unprecedented demand on WA's health and mental health system. The funding boost means 22 additional beds and 278 additional staff across CAHS (**Appendix E**).

1.51 The magnet effect of children's hospitals on communities beyond their natural non-tertiary catchment and the particular impact of such consumer behaviours on the PED are well recognised. In contrast to the WA situation, in most jurisdictions the system managers have implemented formal, tiered paediatric networks, standardisation of practice guidance and expectations of local health service responsibility, in order to facilitate appropriate care as close to home as possible.

Recommendations

The following recommendations result from the findings of the Inquiry and are intended to be read in conjunction with the recommendations of the RCA undertaken in response to Aishwarya's death.

1. The Executive team and senior clinicians approach the family in a process of open disclosure and seek to engage them in a healing dialogue.

2. In acknowledging the devastating tragedy that was the death of Aishwarya, the health system and CAHS engage the family in implementing recommendations and maintaining learnings, improvements and reforms.

3. Expand the PCH capacity to train and support ED staff in communication, partnering with consumers and customer relations.

4. The importance of the parent's extraordinary role in the recognition of deterioration, or indeed any change in the behaviour or health status of their child, be reinforced and embedded throughout all clinical and administrative protocols and training curricula.

5. The Call and Respond Early (CARE) Call system, as adapted to ED settings, be progressed, evaluated, sustained and rolled out across multiple WA locations, as part of Aishwarya's CARE Call, led by the Department.

6. The Executive team engage the Board and the health system clinicians and managers in their shared understanding of the purpose of the RCA, its role within the hospital's safety program and its limitations as an investigative tool.

7. The hospital's RCA policy and procedures include guidance that is issued to both RCA team members and interviewees that clearly outlines their roles, responsibilities, the confidentiality extended to the RCA process, together with how the RCA findings will be used.

8. A consumer-friendly document should explain the purpose and format of the RCA process and clarify how the patient and their family may be involved in the RCA process, the opportunity to be interviewed and when and in what form they will receive the report.

9. The WA Department of Health supports the implementation of the recommendations of the draft Clinical Excellence Division *Review of the Guidance for Procedures Associated with Notification of Reportable Conduct* to provide a clearer more cohesive policy framework for managing complaints and concerns about clinicians.

10. Embed an appropriately resourced ED nursing capability framework and ED-based education team to facilitate career pathways and continuing education.

11. Minimise the use of casual and temporary contract staff in the continuing development of workforce strategies.

12. Plan and monitor the ED workforce to be contemporary, balanced and adequate across the disciplines and the spectrum of seniority.

13. Expand measures to enable junior medical staff to access leave and continuing education.

14. Enhance the structure, function and governance of the PCH Patient Flow Unit (PFU) to optimally coordinate patient referrals and flow, including out of hours, with no inappropriate requests for ED to manage non-ED patients.

15. Progress strategies to enable early discharge of children, such as criteria-based discharge, to improve predictable daily hospital capacity.

16. Elevate the hospital-wide priority placed on children waiting in ED, who require inpatient beds or consultant review.

17. Consumer engagement and participation be openly explored and progressed, with the intent of productive engagement and meaningful partnership.

18. Partner with consumers in progressing a quality improvement framework.

19. Measures be designed and implemented to identify and monitor health care utilisation by CALD patients and families.

20. The organisation review and progress its approach to the development, implementation and monitoring of CALD capability strategies, along with commensurate staff competence training programs, enlisting the support of external agencies and expertise.

21. The framework, work plan and commitments that underpin the implementation of the RCA recommendations and the ANF 10-point Plan be given the highest priority, be appropriately resourced and be designed to be sustainable.

22. Evaluation and monitoring of agreed indicators be incorporated into all of the implementation plans, including the sepsis pathway and trigger tool, and be supported with sustained resourcing.

23. The program of relationship healing and of restoration of trust be fully embraced and maintained, with not only absolute commitment but also appropriate expertise and resources.

24. Embed a learning culture that ensures findings and outcomes of reviews and reports are communicated widely and treated as an ongoing opportunity to reflect and improve systems, processes and activities.

25. Integrate and prioritise clinical risk in the risk management policy and reinforce the escalation pathways for departments and services.

26. Review the organisational and committee structures, aiming to streamline pathways for progression / escalation of clinical and organisational risks, with appropriate engagement of the ED and other service departments.

27. The benefits of sharing and collaboration with other children's hospitals continue to receive appropriate emphasis, particularly in relation to ED and workforce challenges.

28. Reforms identified to enhance, improve and sustain the workforce include regular sharing of information with peers across WA and the nation.

29. CAHS engage the Department of Health in seeking to establish formal networks across children's healthcare in metropolitan and regional WA, with the aim of improving access, encouraging standardisation of care, supporting community confidence in local facilities and managing activity flows.

30. Engage peer-group children's hospitals in response to the national PED trends, warnings and proposed actions identified through the collaborative efforts of the Directors of Australian PEDs.

2. Terms of Reference

The Root Cause Analysis (RCA) report examining the events leading up to Aishwarya's death was completed and provided to her family on 12 May 2021. The RCA report included:

> **Recommendation 6: The organisation conducts an independent external review of the emergency department: staffing, patient flow model, clinical supervision and education programme and ensures the monitoring of serious clinical incidents via regular Morbidity & Mortality Meetings, and the findings from this report are considered to inform the terms of reference of this review.**

Following the completion of the RCA, the Director General of the WA Department of Health (the Department) determined that an Independent Inquiry would be conducted into the Child and Adolescent Health Service (CAHS) in respect of all the functions and operations of Perth Children's Hospital (PCH) concerning the care of Aishwarya Aswath. This Inquiry was established under part 14 of the *Health Services Act 2016* (WA).

The terms of reference:

> **The Independent Inquiry will investigate:**
>
> - **Any matters raised by the Aswath family in relation to the care and treatment of their daughter;**
>
> - **The conduct of the RCA, any issues identified by the RCA, and the recommendations made on the basis of those findings;**
>
> - **The ED's staffing, patient flow model, clinical supervision and education programs (as recommended in the RCA);**
>
> - **The culture of customer service within the ED in relation to children and their families particularly those of culturally and linguistically diverse (CALD) backgrounds;**
>
> - **Roles and responsibilities of clinicians, management and the executive at PCH, and their escalation of issues to the Child and Adolescent Health Service Board;**
>
> - **PCH's clinical incident management processes, including an assessment of previous SAC1 incidents to identify potentially preventable factors;**
>
> - **PCH's clinical risk management processes;**
>
> - **The performance of PCH in relation to safety and quality measures as compared to national peers.**

3. Independent Inquiry Methodology

3.1 Following a call for documentation (Appendix A) sent on 10 June 2021, the Inquiry team received over 3500 documents from the Department, CAHS and its Board. Following this original request, further documentation was sourced from Children's Healthcare Australasia (CHA) who provided additional paediatric emergency department (PED) activity and performance data, incorporating updated benchmarking methodology that compares PCH to children's hospitals in other states. Throughout the course of this Independent Inquiry, further documentation has been sought and provided from a number of sources including members of the CAHS Executive team and the ED Management team.

3.2 The majority of documents were received by 11 July 2021 and the Inquiry team spent the next weeks thoroughly reviewing this material. Regular meetings were held to discuss emerging themes, questions and potential interviewees. The Inquiry team undertook a process of drafting and reviewing questions until it was agreed the questions would suitably answer any gaps identified during the review of documentation. The CAHS Executive team assisted the interview process by providing the names and roles of staff relevant to the Inquiry.

3.3 Interviews were held with clinical and administrative staff and other people with the aim of achieving a balanced view of the issues and matters being investigated by the Independent Inquiry. Interviewees included:
- PCH clinical and management/executive staff
- Current and past members of the CAHS Board
- Members of the RCA Panel
- Internal and external expert consultants
- Consumer representatives.

3.4 Interviews were held via videoconference and teleconference and were assisted by representatives from the Department who ensured interviewees were provided appropriate support before and after attending interviews.

3.5 At all times the Inquiry team found interviewees to be candid in their responses and advanced in their thinking through how systems, policies and procedures might be improved to further enhance safe care within the hospital.

3.6 The Inquiry team conducted six virtual meetings with Aishwarya's parents, Aswath Chavittupara and Prasitha Sasidharan, and the support person and advocate Suresh Rajan, who is the President of the Ethnic Communities Council of WA. The sentiments, learnings and messages received in those discussions left powerful and lasting impressions on the Inquiry team.

3.7 Information obtained from the documentation and through interviews has formed the basis of this Report and the Inquiry team are grateful for the assistance of Aishwarya's family, the Department, PCH, CAHS and all interviewees.

3.8 This report was prepared based on the opinions of the Inquiry team.

4. Findings and Recommendations

The findings and recommendations of this investigation are arranged by the Terms of Reference.

4.1 Any matters raised by the Aswath family in relation to the care and treatment of their daughter

The care of Aishwarya in the PCH Emergency Department

4.1.1   On Saturday 3 April 2021, at 1733 hrs a 7 year old girl with a short history of illness, Aishwarya Aswath, was brought to the Emergency Department (ED) at PCH by her parents, Aswath Chavittupara and Prasitha Sasidharan. Aishwarya's care, her extremely rapid deterioration in the ED and her tragic death has resulted in immense loss, anguish and pain suffered by the family of Aishwarya and constitutes a personal crisis of unimaginable proportions.

4.1.2   Aishwarya was seen and allocated an Australasian Triage Score of 4 , indicating she should be seen by a Medical Practitioner within one hour. The parents had expressed concern about her cold hands. She was then transferred to a waiting area within the ED. The CCTV footage provided to the Inquiry team allows some understanding of the activities and interactions of the period Aishwarya spent at triage and in the waiting room (details provided at 4.1.12 below). She was seen by an ED consultant at 1909 hrs and was transferred to POD B.

4.1.3   Following further deterioration of her condition Aishwarya was transferred to the resuscitation area at 1918 hrs and was declared deceased at 2104 hrs.

4.1.4   Group A Streptococcus (sepsis) (GAS) bacteria were identified in her blood film and subsequently cultured from her blood and other body tissues. GAS commonly colonises the skin, nose or anogenital tract of children but may cause a wide range of clinical disease in children, from mild illnesses such as pharyngitis (sore throat) and impetigo (skin infection), to severe, life-threatening invasive infections (sepsis) associated with significant morbidity and mortality. The Coroner's Court of Western Australia has since confirmed, by correspondence to the family, the cause of Aishwarya's death as "multiorgan failure due to fulminant sepsis (streptococcus pyogenes)".

4.1.5   Sepsis is a time-critical medical emergency that arises when the body's response to an infection damages its own tissues and organs leading to failure of multiple organs, and death if not recognised and not treated promptly. Sepsis can occur in response to various types of infections, including bacterial, viral or fungal infections which are acquired both in community and healthcare settings. Deterioration from sepsis can be rapid and unpredictable, particularly in children. It can also be difficult to identify, as symptoms of sepsis can be common to many other, less consequential, conditions. The Australian Commission on Safety and Quality in Health Care (the Commission) is undertaking a program of work to improve early recognition, treatment, outcomes and post-discharge support for people at risk of or diagnosed with sepsis in Australia. After a national collaborative venture proved unsuccessful in 2017, PCH had developed a local sepsis guideline and, more recently, was working on a pathway and enhanced trigger tool.

4.1.6   The RCA examined the events leading to Aishwarya's death, and actions surrounding her care. The Independent Inquiry has further explored the system issues and factors

that may have influenced how care was delivered on 3 April 2021. As a starting point, the Inquiry team sought to understand matters of concern for Aishwarya's family.

Matters raised by the Aswath family in relation to the care and treatment of their daughter

4.1.7   Members of the Inquiry team met with Aishwarya's parents, Aswath Chavittupara and Prasitha Sasidharan, along with the advocate and support person, Suresh Rajan, by videoconference on six occasions. It was, disappointingly, not possible to meet in person due to the lockdowns and travel restrictions associated with the Delta strain wave of the COVID-19 pandemic. This reality and substantial obstacle was discussed and acknowledged in family interactions. The meetings provided an opportunity to listen to and learn from the family's distress, concerns and specific complaints; to share the intent, commitment and progress of the Inquiry; and to provide timely feedback regarding emerging findings in principle.

4.1.8   The parents and support person shared a number of concerns, perceptions and strongly felt sentiments regarding:
- Gaps in communications, perceived attitudes, engagement, compassion and empathy in the ED triage and waiting areas.
- Unexpected staff movements due to emergencies and breaks, resulting in loss of continuity of staffing and care.
- Challenges in acknowledging and adequately responding to parental concerns regarding severity and deterioration, including cold hands.
- Delays in recognising the nature and severity of Aishwarya's illness and the extreme speed of her deterioration, with related lack of sufficient urgency.
- A deep sense of disbelief: "how could trained professionals have missed the warning signs of such serious illness".
- Related anxieties about competence, experience and training of staff, including perceived failure to have learnt from prior sepsis and similar events.
- Difficulties in the measurement of oxygen saturation in the waiting area.
- Concerns that culturally determined lack of assertiveness by the parents may have detracted from the recognition of urgency.
- The indescribably devastating experience of witnessing rapid deterioration, attempted resuscitation and death of their child.
- The extreme anguish that followed, combined with anger, confusion and mistrust.
- The facilitated opportunity for family and friends to gather and support them in their anguish during the hours after Aishwarya's death.
- Religious and spiritual opportunities or rituals that may have been missed.
- The departure home and subsequent anxious 3am return with sister Amrita.
- Father, Aswath Chavittupara's, clinical collapse and urgent review at Sir Charles Gairdner Hospital.
- Gaps in communication from the hospital in the days after Aishwarya's death.
- Difficulties in understanding the subsequent process, the role of the Coroner's officers and the location of Aishwarya's body.
- Complexities, pressures and uncertainties of the subsequent period of intense media, political and community attention.
- The distress of reviewing the RCA report and dissecting inaccuracies of detail; these included differences between their recollections and timelines on record in the RCA.

4.1.9   Further, Aswath Chavittupara and Prasitha Sasidharan wished the Report to indicate their continuing disagreements concerning:

- Their belief that the decision by the Executive team not to endorse the RCA report was due to insufficient criticism in the findings.
- Persistent feelings of distrust and anxiety that some information is being kept from them.
- Their conviction that the oxygen saturation had not been successfully recorded.
- Their view that Aishwarya's cold hands and cloudy eyes did not receive sufficient emphasis.
- Their recollection of first reporting concern about Aishwarya's cloudy eyes later than shown on the RCA record.
- Lack of progress in their stated wish to obtain a copy of the Closed Circuit Television (CCTV) footage.

4.1.10   The support person and advocate, Suresh Rajan, indicated his view that on the RCA panel, cultural diversity would have been better addressed with specific expertise. He also highlighted that "parent concern" as a trigger of sepsis recognition should receive higher emphasis and score than is done in current tools, such as the PARROT Chart. This approach is supported.

4.1.11   In response to parental concerns and disagreements regarding the CCTV footage timelines recorded in the RCA report, the Inquiry team reviewed and documented the timelines. The table of CCTV footage timelines for the period spent at triage and in the waiting room is provided below. It is noted that following arrival (at 1733 hrs) and triage (no vital signs included), a nursing assessment was conducted at 1750. This was reported in the RCA to have included vital signs and PARROT chart score 2 (could have been 3 out of maximum of 24 if parental concern had been included). The RCA also reports that the assessment was done out of order in response to parental concerns. Prior to that Aishwarya had a brief contact with a junior medical officer at 1741 hrs, reportedly to check her eyes, after the parents had indicated concern at their appearance. In the waiting room there are 5 visits observed by mother Prasitha to the desk. With no sound, the content of those conversations cannot be confirmed. They were all brief but for the one at 1747 hrs. Aishwarya was noted to be lying down for much of the last hour in the waiting room. A nurse saw Aishwarya at 1906 hrs, reportedly to give her antipyretic medication. Aishwarya was seen by an ED consultant at 1909 hrs, reportedly due to concern by this nurse that she could not take the oral medications and was transferred to POD B in father's arms.

Timeline of events recorded in CCTV footage – 03/04/2021	
Time	Event
17:33	Arrive at PCH
17:33	Seen entering triage waiting area
17:33	Family sits down at triage desk
17:35	Triage completed
17:36	Family leave triage waiting area
17:37	Family sit down in a waiting room
17:37	Mother is seen rubbing Aishwarya's hands
17:41	Mother approaches waiting room desk and has interaction with a clerk
17:41	Clerk goes off camera and appears to seek assistance
17:41	Junior Doctor arrives and approaches Aishwarya
17:42	Junior Doctor leaves interaction
17:42	Mother returns to the waiting room desk and speaks to a clerk
17:43	Clerk leaves waiting room
17:46	Mother approaches waiting room desk and has interaction with a clerk
17:49	A Nurse and student nurse arrive with a clerk who identifies the family
17:49	Nurse and student nurse converse with Father

Timeline of events recorded in CCTV footage – 03/04/2021	
17:50	Nurse and student nurse go to desk
17:51	Mother returns to family
17:51	Parents seen rubbing Aishwarya's hands again
17:52	Nurse and student nurse commence observations
17:55	Student nurse goes off camera
17:55	Student nurse returns with different monitoring equipment
17:57	Nurse places pulse oximeter sensor on foot
18:00	Observations completed
18:39	Mother approaches waiting room desk and interacts with a clerk
18:57	Mother approaches waiting room desk and interacts with a clerk
19:06	A Nurse approaches the family and interacts with Aishwarya
19:08	Nurse leaves waiting room
19:09	Nurse returns with a Consultant
19:10	Consultant leaves
19:10	Nurse follows
19:11	Family follows with Father carrying Aishwarya

4.1.12 The series of virtual meetings with the family allowed a detailed exploration of recollections, feelings and reactions, as expressed by Aishwarya's parents. The Inquiry team was able to listen and learn as well as engage in some sharing of emotions and information. However, specific questions could not always be resolved. It was explained that the RCA process, undertaken by a broad-based team of both internal and external/independent professionals, as well as consumer and Department of Health participation, had addressed many of the above matters in specific detail, with the Report provided to the family. The process, findings and recommendations of that RCA are fully addressed elsewhere in this Report. It is, however, understood that the family do not agree with some aspects of the RCA record, as outlined in the points above. In addition, the Coronial process and its potential further contributions were discussed. During the conduct of this Inquiry, correspondence from the Coroner's Court of Western Australia was received by the family, confirming the cause of death as "multiorgan failure due to fulminant sepsis (streptococcus pyogenes)".

4.1.13 Consistent with its Terms of Reference, this Inquiry identified systemic gaps and opportunities for improvement. The information was presented and discussed in considerable detail with the family. There were periods of reflection on the findings of multiple factors and potential contributions in the care received by Aishwarya, consequently identified as targets for improvement. Discussions also encompassed the difficulties in recognising sepsis and the well described and published capacity for this organism to cause extremely rapid deterioration after periods of relative stability, especially in a child.

4.1.14 The family shared concerns regarding their culturally determined propensity not to be assertive and apply pressure to staff, despite their fears and sense of abandonment. The Inquiry team reflected on these concerns and offered assurance that Aishwarya's parents did all that any parents could do in the circumstances.

4.1.15 The implementation of the RCA recommendations will address some of the concerns expressed by the family. The conduct, findings and recommendations of this Inquiry will enhance, broaden, and progress those commitments. Such findings relate to the gaps in executive notification on the night of Aishwarya's death as well as in communication and support mobilised after her death. Open disclosure was not able to be fully exercised in accordance with the CAHS policy and remains incomplete. The ongoing support of the family raises further domains for potential improvement,

such as the engagement of general practitioners, community services and culturally appropriate emotional and spiritual care.

4.1.16　Through the anguish of loss and despair, Aishwarya's parents became increasingly committed to honour the memory and legacy of Aishwarya by seeking to create an improved healthcare system for children. Aishwarya's CARE Call at WA state-wide level, along with a broad range of substantial reforms, improvements and enhancements at PCH/CAHS are well aligned with that commitment by the family. The Inquiry team were privileged to accept a role and a responsibility in that task of promoting sustainable system improvement.

Key findings

4.1.17　Aishwarya's care, her extremely rapid deterioration in the ED and her tragic death has resulted in immense loss, anguish and pain suffered by the family of Aishwarya and constitutes a personal crisis of unimaginable proportions.

4.1.18　Group A Streptococcus (GAS) bacteria were identified in Aishwarya's blood film and subsequently cultured from her blood and other body tissues. The Coroner's Court of Western Australia has since confirmed, by correspondence to the family, the cause of Aishwarya's death as "multiorgan failure due to fulminant sepsis (streptococcus pyogenes)".

4.1.19　Members of the Inquiry team met with Aishwarya's parents, Aswath Chavittupara and Prasitha Sasidharan, along with the advocate and support person, Suresh Rajan, by videoconferencing on six occasions. The family and the advocate shared a number of concerns, perceptions and strongly felt sentiments. They expressed anguish, anger and disbelief. Urgency, communication and compassion were felt to have been inadequate.

4.1.20　The family were troubled and unconvinced about the RCA conduct, record and findings, as well as the subsequent process of acceptance without endorsement. They wished the Inquiry Report to indicate their points of disagreement with the RCA and their level of distrust in the system.

4.1.21　Through the anguish of loss and despair, Aishwarya's parents became increasingly committed to honour the memory and legacy of Aishwarya by seeking to create an improved healthcare system for children.

Recommendations

1. The Executive team and senior clinicians approach the family in a process of open disclosure and seek to engage them in a healing dialogue.

2. In acknowledging the devastating tragedy that was the death of Aishwarya, the health system and CAHS engage the family in implementing recommendations and maintaining learnings, improvements and reforms.

3. Expand the PCH capacity to train and support ED staff in communication, partnering with consumers and customer relations.

4. The importance of the parent's extraordinary role in the recognition of deterioration, or indeed any change in the behaviour or health status of their child, be reinforced and embedded throughout all clinical and administrative protocols and training curricula.

5. The Call and Respond Early (CARE) Call system, as adapted to ED settings, be progressed, evaluated, sustained and rolled out across multiple WA locations, as part of Aishwarya's CARE Call, led by the Department.

4.2 The conduct of the RCA, any issues identified by the RCA, and the recommendations made on the basis of those findings

The Root Cause Analysis undertaken in response to Aishwarya's death

4.2.1   The Department of Health has developed and implemented a comprehensive safety system which aims to protect the people of Western Australia from harm related to healthcare. As part of its safety program, the Department of Health has published a Clinical Incident Management Toolkit which provides guidance to health service providers for the:
- Identification of hazards before they cause patient harm and their review in terms of clinical risks;
- Identification of incidents when patients are harmed or near misses and the implementation of strategies to minimise harm; and
- Provision of opportunities to share lessons learned and action to reduce risk of similar events occurring.

4.2.2   Where there is an unexpected death, the health service must review the circumstances surrounding the care provided to the patient. PCH has implemented a safety program which includes the review of serious clinical incidents and unexpected deaths. The death of Aishwarya Aswath required the hospital to conduct an RCA as a means of investigating the circumstances surrounding her death and to identify any opportunities to improve care and care outcomes in the future.

4.2.3   The RCA panel convened by the hospital was larger than usual and engaged people with broad ranging expertise including a number of people who were independent of the operations of the hospital but who had expertise in the carriage and conduct of RCA processes. RCA panel members stated that the team was cohesive, included members with the relevant skills to undertake such a review, and that members felt unrestricted, which allowed them to have open and honest discussions and exploration of the circumstances surrounding Aishwarya's care and death. During interviews with the Inquiry team, the panel members were not unanimous on all aspects of the process but all expressed support of the recommendations.

4.2.4   The RCA conducted by the panel was robust and diligent. During interviews undertaken by the Inquiry team, the RCA panel stated that its members believed that all relevant factors had been considered, although less than the expected time was allocated for the process and the pressure of time to complete the investigation and the report remained a factor for the panel. It was stated that there was some confusion over the date for completion of the report which resulted in the report needing to be issued earlier than had been anticipated by the RCA panel. The RCA panel supported the view that the conduct of the RCA met the requirements of the Department of Health policy.

4.2.5   The RCA panel acknowledged that it was unable to determine the influence of some factors in relation to the quality of the care provided to Aishwarya and where this was the case the RCA panel, in general, took a view to consider all potentially contributing factors as worthy of further work. The Inquiry team acknowledges that the RCA had a very low threshold for inclusion of factors that may have contributed to Aishwarya's tragic death.

4.2.6   The systemic process used in the attempt to identify the root cause of a problem or event, including issues with structures, processes and frameworks, is aimed at

providing management with recommendations to minimise the risk of further such events. RCA reports require further explanation if useful discussion is to be held with people not familiar with the process, its purpose or the style, format and the intention of the recommendations.

4.2.7 After the death of Aishwarya, open disclosure and communication with her family proved difficult. The explanations provided by the paediatrician on call during the return visit, to check sister Amrita early the next day, were only able to be attended by Prasitha Sasidharan, as Aswath Chavittupara had been taken to Sir Charles Gairdner Hospital. Aishwarya's parents have provided a number of reasons behind their decision not to engage with the hospital. These relate to a loss of trust in the hospital and their belief that some of information it provided was incorrect. Unfortunately, this breakdown in trust exacerbated the family's grief and, among other outcomes, hindered the hospital delivering the support and information it would otherwise have provided the family.

4.2.8 To assist Aishwarya's parents in understanding the RCA report, a family-friendly summary was developed, as was normal practice at PCH, which included explanation of terms and processes. However, to avoid the perception of inappropriate influence, this version of the report was not provided to the family.

4.2.9 Receiving the full RCA report without explanation of some matters has added to the concerns of Aishwarya's parents and has not assisted their understanding of the tragic death of their daughter or helped their relationship with the hospital. In analysing the report, the family identified discrepancies in some descriptions and specific timelines on the record as distinct from their recollection. In addition, review of the CCTV footage undertaken by the Inquiry team revealed possible discrepancies in the alignment of certain testimonies and timelines recorded. To exemplify, the description of an interaction of the family with staff at the desk recorded at 1745 may fit better with another interaction seen to have occurred at 1840. The Inquiry team discussed these latter differences with the RCA panel and possible errors of transcription and/or testimony were acknowledged.

4.2.10 The decision by the Executive team to not endorse the RCA report was interpreted by the family to mean that the RCA report was determined to be insufficiently critical in their findings.

4.2.11 Further, the RCA report was unfortunately released to the public via the media. While RCA findings are at times discussed in the media this is with expert clinician explanation and the provision of contextual information. The purpose of the RCA process is to guide improvements in care and outcomes, to achieve this it is imperative that staff and consumers participating in RCA's feel confident that the RCA process is followed.

4.2.12 The RCA report indicates a number of contributing factors and root causes. These have been extracted from the RCA report and pasted verbatim below:
- The lack of a comprehensive triage, including a limited primary assessment of the patient, resulted in a triage score of 4 which led the patient to be allocated a wait time of 1 hour to be seen by medical staff which contributed in a delay in medical intervention.
- A lack of recognition of persistent and significant parental concerns as a significant clinical concern to be escalated resulted in a delay in treatment which may have contributed to the patient's outcome.
- A lack of a formalised escalation process for families resulted in no clear pathway for seeking more senior assistance which contributed to the patient outcome.

- Incomplete clinical handover between staff resulted in non-urgent escalation and contributed to delay in treatment.
- The demands of senior nurses to fulfil an increasing service role rather than supervisory role has impacted on the ability to facilitate planned education and supervision of junior nurses that may have decreased their knowledge and skill set when assessing a sick patient.
- A failure to identify an abnormal temperature against a clearly defined prompt on the PARROT chart to consider sepsis resulted in non-escalation which may have contributed to the patient outcome.
- The lack of knowledge of the parental concern score on the PARROT chart is to be actioned for the ED and not only for inpatients resulted in a lower escalation score and contributed to the non-escalation of the patient's treatment.
- The lack of knowledge/ skills and competence to recognise an unwell patient resulted in delayed escalation of the clinical care which may have contributed to the patient's outcome.
- The perceived lack of cultural awareness by staff for culturally and linguistic diverse (CALD) families and patients may have resulted in non-recognition of the family's significant concerns whilst attempting to escalate care which may have contributed to the delay in clinical intervention.
- The workplace design of the triage area resulted in limited accessibility to physically reach the patients and take observations which contributed to an incomplete assessment.
- There is limited privacy in the waiting room to do an extensive physical assessment.
- Since Oct 2020, senior clinicians had escalated substantial concerns around patient safety to senior management. The panel found that these risks had not been effectively mitigated until recently.
- A culture has developed which saw escalation as futile and ineffective with subsequent failure to call for assistance at times of increased acuity & activity (more obvious among nursing staff), even when there was availability of senior CNS from outside ED.
- Uncovered sick leave of medical staff resulted in a reduction in available medical staff during the evening, delays in medical assessments/prolonged waiting times and impeded the capacity for medical staff to provide a more comprehensive response to parental escalation. These factors may have contributed to a delay in recognition of the severity of illness and initiation of treatment.
- Group A Streptococcus sepsis resulted in the rapid progression of deterioration in the patient which contributed to the patient outcome.
- The lack of a second or a consistently working blood gas machine in the ED resulted in a delayed first blood gas reading during the resuscitation which may have contributed to delayed intervention or an inaccurate reading.
- Since COVID-19 individual rooms in PODs keep their equipment outside the room due to infection control. This allows for misplacement of equipment. RN2 spent several minutes trying finding appropriately sized BP cuff which may have delayed assessment.
- The lack of an available contemporaneous, identifiable, non-editable and visible electronic system for recording handover of clinical information resulted in a fragmented response to escalation attempts by the family which led to a delayed escalation of care and may have contributed to the outcome.
- The lack of a triage process policy, which includes minimum practice standards for the triage, assessment and care for the management of patient's presenting to the ED, resulted in an incomplete triage which contributed to a failure to recognise the clinical condition of this patient.

- The lack of an established sepsis recognition tool and escalation pathway in ED resulted in initial non-recognition of the patient's condition resulted in a delay in escalation which may have contributed to the outcome.
- The practice at triage of not taking a manual pulse or feeling the skin may have contributed to a limited assessment and under recognition of how sick this patient was.
- The lack of an established sepsis recognition tool and escalation pathway in ED resulted in initial non-recognition of the patient's condition and resulted in a delay in escalation which may have contributed to the outcome.
- The lack of a clear pathway for parents and caregivers to escalate their concerns to staff, uncoordinated staff response and documentation of that response led to a delay in the initiation of treatment and may have contributed to the outcome.
- A lack of clinical supervision resulted in further missed opportunities to ensure support to staff to recognise a sick patient which contributed to a delay in clinical intervention.
- Having the waiting room nurse as a member of the resuscitation team resulting in the waiting room being effectively unattended during resuscitations, led to fragmented care, a delay in reassessment, and may have contributed to the outcome.
- The removal of the waiting room nurse resulted in a delay in comprehensive assessment and may have contributed to the patient outcome.

4.2.13 In response to these findings, the RCA made the following recommendations:

- **Develop and implement policy for triage practice including detailed descriptors for the triage, assessment and care for the management of patient's presenting to the ED.**

- **Develop and implement a model for clinical supervision to support all staff in their clinical decision making.**

- **Review and align nursing clinical roles and responsibilities in ED and align to a capability framework.**

- **Develop and implement a model for a parental escalation process in ED- aligning with the inpatient 'Call and Respond Early' (CARE) Call in consultation with consumer representatives.**

- **Ensure contemporaneous education and use of the PARROT (V3) chart is conducted, evaluated and reported.**

- **The organisation conducts an independent external review of the emergency department: staffing, patient flow model, clinical supervision and education programme and ensures the monitoring of serious clinical incidents via regular Morbidity & Mortality Meetings, and the findings from this report are considered to inform the terms of reference of this review.**

- **The organisation implements an awareness program focusing on CALD populations to ensure patient safety in the ED.**

- **Purchase a second blood gas machine for the ED.**

- **Review and adapt the physical layout of the triage area in ED to facilitate improvements to triage and assessment processes.**

- **Develop and implement a robust system of medical unexpected leave (including sick leave) cover in ED.**

- **Develop and implement enhanced functionality to Emergency Department Information System (EDIS) or an Electronic Medical Record (EMR) to enable safe handover of clinical information.**

4.2.14 The Inquiry team formed the view that these recommendations were relevant and appropriate. Their implementation is essential to ensuring patient safety in the ED through meeting the increased demand with appropriate staffing levels and improved processes. The hospital has described and put in place a comprehensive enactment process to manage the implementation of the recommendations **(Appendix B)**. However, this will require the ongoing focus of management and the allocation of adequate and ongoing resources to ensure they are fully implemented and embedded in the operations of the hospital.

ANF 10-point Plan

4.2.15 In addition to the 11 recommendations from the RCA report, the ANF provided a 10-point Plan. The ANF plan overlaps in part with a number of the RCA recommendations. The ten elements of the plan are:

- **Implement a staff allocation of 1 nurse for every three patients**

- **Shift coordinators and triage nurses not included in floor numbers of dot point one - which means they don't take a patient load**

- **Supernumerary resuscitation team – minimum of 4 nurses for the resuscitation team would also be available to assist the floor staff with category 2 patients and patients with behavioural problems**

- **Engagement from the PCH Executive team on a PCH Emergency Department Taskforce that includes nursing representation. This will be a Staff Led Taskforce with key performance indicators to manage the transition and oversee the implementation of the above dot points as well as looking at ways to recruit additional staff to the department in a timely manner.**

- **Double the number of Staff Development Nurses in the Emergency Department**

- **Open the Paediatric Critical Care Unit to its full capabilities so that it can function as an Intensive Care Unit and High Dependency Unit.**

- **A clearly articulated Winter/Surge Bed Management Strategy that is published and available to all staff and the community.**

- **Fast track recruitment with a maximum turnaround time of 4 weeks. That is no more than 4 weeks from application to working the first shift.**

- **3C (the short stay surgical unit) that currently closes at 3.30pm on Saturday needs to be kept open 24/7 on the weekend and staffed appropriately as this will reduce access block.**

> - **Additional numbers of specifically trained paediatric security staff for the Perth Children's hospital.**

4.2.16 Action taken by CAHS in response to the 10-point Plan, as advised to the Inquiry team, shown in **Appendix C**.

How was this RCA process different?

4.2.17 There were a number of areas where this RCA differed from RCAs previously conducted within the hospital. It is likely that many of these differences were the result of the high level of public concern that followed the death of Aishwarya. The hospital had generally convened panels of three people, whereas this panel comprised twelve members. The extended panel membership does not seem to have adversely affected the conduct or the outcome of the panel's deliberations, however the size did introduce a complexity which prior panels had not experienced and was compounded by the shortened timeframe to complete the investigation.

4.2.18 The RCA panel included an observer from the Department of Health, a consumer representative and external independent expert representatives. These additions to the panel did not appear to hinder the panel in the conduct or the carriage of its tasks, but did add to its complexity. Some panel members expressed reservations about the membership and process but all supported the recommendations.

4.2.19 The RCA was carried out against a background of intense media interest and speculation. Given this coverage it must have been extremely difficult, if not impossible, for the RCA panel or interviewees to have been unaware of the background commentary.

Management's decision to endorse the RCA recommendations

4.2.20 Finalised RCA reports are presented to the Chief Executive (CE) (or equivalent) for signoff and endorsement. The health service executive management team accepts RCA recommendations on the basis that they are appropriate as a remedy, have addressed the issues and that their implementation is achievable.

4.2.21 The CE, in consultation with his Executive team, decided not to sign off the entire RCA report into Aishwarya's death. The Executive team stated that timelines were tight between them receiving the RCA and having time to engage and discuss as usually occurred with an RCA. Secondly, they questioned whether all recommendations were supported by the findings or "narrative". Thirdly, they did not feel that they were empowered to accept, comment or modify the report because they were implicit in the systems problems which it describes.

4.2.22 Management is responsible for the day-to-day operations of health services, it is difficult to identify how these findings differently involve management than other RCA findings. In hindsight, the decision not to endorse the full RCA narrative has created misunderstanding and confusion, with no apparent benefit and is considered to have been unhelpful.

4.2.23 The CE accepted the RCA recommendations and commenced a series of actions to implement the recommendations and to address the shortcomings identified by the RCA report. Strategies were developed and a reporting system commenced to record the progress of the implementation program. Appropriate resources were allocated by management and more recently by the West Australian Government through its

enhanced health budget to achieve the recommended outcomes **(Appendix D and E)**.

4.2.24   Management's decision to accept the recommendations of the RCA but not the entire RCA narrative discredited the standing of the RCA process within the hospital and resulted in media speculation and negative comment together with the resultant adverse public discourse. The constant and ongoing negative comments by the media and the response of the community further worked to degrade the relationships within the hospital and the trust by families in the organisation and, reportedly, clinicians. The discourse around the RCA report and the referral of staff to Australian Health Practitioner Regulation Agency (Ahpra), undertaken as per the requirements of the Health Services Act 2016-Section 146, have blurred the public's understanding of the purpose of the RCA. The referral of staff members to Ahpra was perceived by staff as a misuse of the RCA process.

4.2.25   The various policies promulgated by the WA Department of Health, together with the further overlay of local policies, which deal with both mandatory reporting obligations and management of adverse clinical incidents may also have contributed to some confusion and lack of clarity about how these various requirements are to be managed in a way that ensures strong accountability on the part of health service providers, whilst ensuring appropriate identification and addressing of system issues arising from the examination of serious adverse incidents. Opportunities for improving the policy framework for managing serious adverse incidents and the role of mandatory reporting within that framework have been identified in a recent review (draft) conducted by the Clinical Excellence Division of the Department of Health, titled *A Review of the Guidance for Procedures Associated with Notification of Reportable Conduct*.

4.2.26   There are a number of areas that will need to be addressed if the damaged relationships within the hospital are to be corrected and trust re-established. Staff need to be assured through policy and practice that the intent of an RCA investigation is on system wide improvement, not blame of individual practice. Good clinical governance requires trust and collaboration between all members of the health service team.

4.2.27   The RCA policy and procedures need to include guidance to be issued to both RCA panel members and interviewees that clearly outline their roles, responsibilities, the confidentiality extended to the RCA process together with how the RCA findings will be used. It is also important to have procedures in place that clarify how the patient and their family will be involved, interviewed and receive the report. Boards need to be clear on their role within and understanding of the RCA process. These procedures should incorporate the support and wellbeing of all those involved with the RCA: the family, the panel, staff interviewed and staff involved with care of the patient.

4.2.28   With the majority of the recommendations relating specifically to the ED, consideration might be given to appointing one of the new nursing positions as a dedicated project officer, reporting to the ED Clinical Nurse Manager to ensure recommendations are embedded and sustainable.

4.2.29   The RCA panel was provided with CCTV footage of the ED for the period of Aishwarya's waiting and care. The use of recorded vision is important and of significant value to any investigation, however, without accompanying audio its limitations need to be understood and accepted. Further, RCA guidance needs to describe when, how and why CCTV footage can inform an investigation. This process

should include appropriate support for the RCA panel, particularly non-clinicians, in viewing these images.

Key findings

4.2.30　The death of Aishwarya required the hospital to conduct an RCA. The Inquiry team found the conduct of the RCA by the panel to have been robust and diligent, with a rigorous examination of the factors that may have contributed to this tragic death.

4.2.31　After the death of Aishwarya, open disclosure and communication with her family proved difficult. Unfortunately, this breakdown in trust exacerbated the family's grief and, among other outcomes, hindered PCH in delivering the support and information it would otherwise have provided the family.

4.2.32　Receiving the full RCA report without explanation of some matters has added to the concerns of Aishwarya's parents and has not assisted their understanding of the tragic death of their daughter or helped their relationship with the hospital. In analysing the report, the family identified discrepancies in some descriptions and specific timelines on the record as distinct from their recollection.

4.2.33　The Inquiry team formed the view that the RCA recommendations were relevant and appropriate. Their implementation is essential to ensure patient safety within the ED. The hospital has described and put in place a comprehensive enactment process to manage the implementation of the recommendations.

Recommendations

6.　The Executive team engage the Board and the health system clinicians and managers in their shared understanding of the purpose of the RCA, its role within the hospital's safety program and its limitations as an investigative tool.

7.　The hospital's RCA policy and procedures include guidance that is issued to both RCA team members and interviewees that clearly outlines their roles, responsibilities, the confidentiality extended to the RCA process, together with how the RCA findings will be used.

8.　A consumer-friendly document should explain the purpose and format of the RCA process and clarify how the patient and their family may be involved in the RCA process, the opportunity to be interviewed and when and in what form they will receive the report.

9.　The WA Department of Health supports the implementation of the recommendations of the draft Clinical Excellence Division *Review of the Guidance for Procedures Associated with Notification of Reportable Conduct* to provide a clearer more cohesive policy framework for managing complaints and concerns about clinicians.

4.3 The ED's staffing, patient flow model, clinical supervision and education programs (as recommended in the RCA)

Relocation to a new hospital

4.3.1   Western Australia's first dedicated children's hospital was established in 1909 as Perth's Children's Hospital and in 1949 was renamed Princess Margaret Hospital for Children (PMH). PMH was replaced by PCH with a staged opening in mid-2018. At that time, CAHS comprised PMH, Child and Adolescent Community Health, Child and Adolescent Mental Health Service and Perth Children's Hospital Project. At its closure, PMH had approximately 220 beds and provided care for more than 280,000 children each year. CAHS now comprises PCH, Neonatology, Community Health, and Child and Adolescent Mental Health Service.

4.3.2   The new hospital's design is innovative and engaging, incorporating family-friendly design elements; increased waiting areas and interactive spaces for families and staff; and greater distance between wards and departments. In addition, the layout within wards and departments is very different from PMH.

4.3.3   The transfer to the new ED at PCH was welcomed by staff as it was substantially bigger, with greater resuscitation space, additional short stay ward beds with added privacy, enhanced triage capability and dedicated waiting areas. There had been a comprehensive commissioning process that had signed off on appropriate staffing and procedures. However, interviewed clinicians noted that, with experience, additional challenges have arisen in staffing the new ED design, with specific reference to nursing staff for triage and waiting areas.

4.3.4   Further, the triage desk, which was designed with the safety of staff in mind, was not found to be conducive to enhanced interactions with families or ease of assessment of children. These interactions were further compromised in 2020 by COVID-19 restrictions, including impediments to physical assessment. 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. As a consequence of insufficient nursing staff, ED operational flow, patient experience and patient safety were impacted.

4.3.5   While the opening of PCH was originally to include an Electronic Medical Record this also did not eventuate and is still not in place. Interviewees commented on the shortcomings in history taking, sharing of information and communication in a large department exacerbated by an essentially paper based medical record.

4.3.6   Documentation provided to the Inquiry provides evidence that PCH has in place a large range of policies, frameworks, guidelines and protocols including state-wide, locally developed and department-specific resources. A range of new policies, procedures, guidelines and protocols were developed for the establishment of PCH including some intended to reflect the changed environment, increased capacity for patients and integration of some services.

4.3.7   There are many challenges when transitioning to a new hospital and compromises to the original vision are sometimes required in response to emerging issues, fluctuating funding sources, and changing priorities. The hospital workforce had experienced a number of challenges impacting on morale. The lead up to the move from PMH to PCH had placed added pressures on staff through extra time spent planning new buildings and models of care in addition to their existing workloads. This pressure

was exacerbated by the delayed opening of the new hospital. Staff worked for a number of years in an increasingly tired and outdated facility.

4.3.8   Documents provided to the Inquiry team and subsequent interviews described reforms led by the Executive team since 2018, in an effort to address the identified concerns and factors influencing low morale within the hospital and to foster a values-based organisation.

Pressures and challenges for the ED

4.3.9   WA had led the nation in the introduction of 4 hr ED targets in 2009. By 2012, other jurisdictions aligned with the introduction of the federal government's 4 hr emergency performance target. PMH invested in those commitments with hospital wide initiatives being implemented to support the targets. Access Block (the percentage of patients waiting more than 8 hrs for an inpatient bed) had at times approached 25%. Benchmarking data subsequently demonstrated excellent performance at PMH that, for a long time, exceeded children's hospital peers.

4.3.10   These interventions appear to have lost traction over time. With the subsequent and continued increase in ED demand and the pressures on hospital capacity, performance deteriorated. In November 2018, at the Australasian College for Emergency Medicine (ACEM) ED accreditation, access block was noted to be a problem for the new hospital but it was reported that steps were being taken to address this. The PCH ED activity and its performance reflect both national and international trends and challenges in paediatric emergency care in the period up to and including 2021.

4.3.11   Similar to other jurisdictions, PCH ED experienced some reduction in demand, from mid-2019 to mid-2020. This reversed towards the end of 2020 when, as a secondary effect of the COVID-19 pandemic, there was a substantial increase in daily presentations due to unseasonal respiratory illnesses and adolescent mental health patients, with many requiring admission for inpatient care. Mental health emergency presentations in the child and adolescent population have increased internationally and across all Australian states. This activity and case mix require particular models of care that depend on rapid expert assessment and intervention. Adolescent mental health patients bring significant risk and acuity to the clinical environment, particularly when de-escalation of behavioural challenges is not possible. Subsequent care, observation, intervention and safety require a co-designed skill set to effectively manage the child and their family. There were views expressed to the Inquiry that prior to April 2021 the Executive team and the health system did not fully appreciate the profound effect this additional demand had on the morale and the functioning of the ED, particularly given the increasing episodes of aggression.

4.3.12   Proposals to access the non-tertiary care of children closer to their homes, have not been effective in lessening demand on PCH. Attempts to transfer admitted patients from the newly opened PCH (ED and wards) to more appropriate, close-to-home or non-tertiary care was reported to be difficult and complex. The relationship with other hospitals providing paediatric emergency and inpatient services was not formalised and lacked structure. This added to the increased demand at PCH.

4.3.13   This Inquiry, in keeping with the terms of reference provided to it, examines how these complex, contextual issues impacted the circumstances within the ED on the 3rd of April 2021.

Staffing - Nursing workforce

4.3.14   Nursing, particularly registered nurses, constitute the single largest clinical workforce in Australian hospitals and health services. This is a female dominated profession and career interruptions regularly occur. WA has had a historical shortage of nurses and relies heavily on both international and national candidates to support and maintain adequate registered nurse numbers. The COVID-19 pandemic severely impeded access to workforce travel and recruitment.

4.3.15   WA nursing workforce capacity, particularly in the metropolitan ED's, has been impacted heavily by COVID-19 with many nurses responding to the needs and opportunities presented by the COVID-19 screening and vaccination programs.

4.3.16   Nursing workforce stability at PCH has been a long-identified issue and was highlighted in the PMH Review of 2017. In the absence of adequate recruitment and retention strategies, there has been a historic reliance on either temporary (fixed term contracts) or casual workforce, predominantly to support nursing vacancies and unplanned leave. Sector reports comparing casual pool size and utilization across major inner-city Perth EDs demonstrate higher casual pool numbers per bed base at PCH compared to adult and mixed ED's.

4.3.17   With a history of low levels of full-time permanency in its nursing workforce, PCH was particularly vulnerable to the adverse, direct and indirect, impact of the COVID-19 pandemic. The recruitment process was described to the Inquiry team as complex and drawn out, with delays in responding to emerging needs in the ED. Many senior nursing staff were understood to be acting in their roles and some had acted for long periods.

4.3.18   Chronic shortages in the registered nurse workforce have also seen an increase in the use of both Enrolled Nurses and Assistants in Nursing. Such roles require significant clinical supervision from a senior registered nurse and may not be well suited to a paediatric ED where activity and case mix are unpredictable and frequently undifferentiated.

Nursing education, training and clinical supervision

4.3.19   The education and training required to develop, maintain and supervise an ED nursing workforce is both comprehensive and constant. A robust capability framework must exist to support both the individual in professional career development and the service in maintaining and developing adequately skilled staff for safe predictable service delivery. Curriculum development and education delivery requires Nurse Educator direction.

4.3.20   Clinical supervision is a core component of professional support for contemporary nursing practice. The health and wellbeing of nurses is vital for recruitment and retention and ultimately a healthy and sustainable workforce. There is also emerging evidence that clinical supervision of health-care staff impacts positively on outcomes for service-users.

4.3.21   ED Nursing education and training issues of note:
- ED Nurse Manager capacity to implement and monitor guidelines and policies may be improved by staff development nurses (SDN) direct reporting lines and role clarity.
- Limited opportunities to partner with consumers and include the patient experience, along with the value of parental concern, in education.
- Of the reviewed nurse education/study days no sessions were identified focusing on communication. This may include challenging scenarios and difficult

conversations, as well as structured communication across all aspects of care, including in triage.

- Limited opportunities for interdisciplinary education and training.
- Concerns regarding ability to orient and supervise large volumes of new staff on an ongoing basis:
    - o Adult trained RNs, casuals, ward nurses in ED
    - o Currently 4-week induction plan.
- Limited opportunity to quarantine nursing time for education and training.

Medical workforce and wellbeing

4.3.22   The medical workforce appears to be less severely affected by staffing shortages, although subject to similar issues to the nursing staff regarding history, workforce numbers along with the impact of closed state borders. Issues of note include:

- Problems with covering sick leave and unfilled vacancies in medical staffing
- Junior medical staff unable to take annual or other leave, with departments being expected to manage this internally; planning and communication around these challenges was portrayed as suboptimal.
- Medical staff compensating in work practices for nursing shortages.

4.3.23   Benchmarking with similar PEDs demonstrates medical staffing numbers and seniority are comparable. Staff reported that inadequate provision for urgent or unplanned gaps in rosters regularly resulted in reduced numbers of medical staff.

4.3.24   Junior medical staff spoke highly of the hospital but also reflected on opportunities to better support their wellbeing. The Inquiry team was informed of exemplars in the Wellness Program, such as "Paeds in a pod" and "Lighten the load". The training programs and clinical supervision were appreciated but the inevitable impediments in regular attendance, due to surges in workload, were identified. With recent pressures of increased activity and reduced staff numbers, these challenges had exacerbated.

4.3.25   The ACEM accreditation took place in November 2018 in the new PCH ED. They commended the strong clinical leadership in the PED. They reported the deterioration in access block and the impact this was having on the PEDs ability to function They identified 3 hours protected teaching for ED trainees with a strong culture of teaching, research and training. The need for two consultants across 16 hours a day, over the weekend, was highlighted as a requirement for accreditation in clinical supervision. They mentioned good relationships between trainees and PED consultants and good relationships between nursing and medical staff. Overall, there is a strong sense of collegiality and pride in the department and the staff who work there.

4.3.26   The Inquiry team learnt of the huge impact Aishwarya's death has had on the morale of all staff, including the junior medical ranks. As well as dealing with the tragic death of a child, they faced immense media and community scrutiny and criticism. The limited communication, along with the anger and confusion regarding the Ahpra referrals were described as undermining trust in the workplace.

Patient flow model

4.3.27   Western Australia has been considered a national leader in management of ED patient flow. Four-hour targets were introduced in 2009 and then the Western Australian Emergency Access Target (WEAT) was added in 2016, using clinical service redesign methodologies to improve performance. Access block refers to patients who require hospital admission and are delayed from leaving the ED. When

access block is high, patient safety is compromised for all patients in the ED. Delays in assessment and treatment, increased risk of error, increase hospital length of stay all contribute to worsening health outcomes.

4.3.28   Ensuring timely access for admission to hospital for all children who require elective, or emergency inpatient beds requires robust, appropriately resourced hospital wide processes and constant oversight. Patient flow organisational structures and procedures require multidisciplinary leadership and active collaboration. The PCH ED admits an average of 15% of presenting children to hospital inpatient beds with a further 5% admitted to the Emergency Department Short Stay Unit. A number of the historically outstanding ED metrics, where PCH had led the nation, have somewhat deteriorated in recent times. There has been a gradual reduction in WEAT performance with an increase in ED length of stay. The PCH overall WEAT performance (90% target) was 92% in 2012 and had dropped to 80% in 2021. It is important to recognise, however, that the WEAT figure for children discharged directly from the ED (representing 80% of all presentations) is documented at 87% in the most recent quarter, which remains exemplary. These numbers indicate efficient performance within the ED but highlight the impact of persistent and increasing access block at PCH.

4.3.29   ED models of care are designed to improve the operational efficiency and safety of the ED. The front of house model of care includes triage, waiting room and ambulance management. A nurse-led team manages the initial triage, assessment and nurse-initiated care. Triage is the process of assessment of a child on arrival to the ED to determine the priority for medical care based on the clinical urgency of the patient's presenting problem. ED operations and flow depend on nursing expertise, where an extended scope of practice enables not only the triage and the comprehensive assessment of a child, but ongoing monitoring and recognition of deterioration, as well as the commencement of care pathways such as sepsis and asthma. These initiatives require the registered nurse to practise advanced critical thinking, reflection and clinical risk management.

4.3.30   The new ED at PCH had been physically designed with children and families in mind, intended to enhance ED models of care and waiting room functionality. The new ED occupies an 88% bigger footprint and provides 48% more treatment spaces. A comprehensive service plan was developed and signed off, that described new models of care and the workforce required for commissioning. Interviewed staff commented on their subsequent experience that without additional staff, the new physically larger ED and waiting room design meant less connectivity and higher risks. As highlighted by the RCA, the triage process at PCH was found to be inadequate.

4.3.31   Opportunities to benchmark with comparable services around the nation and beyond are an important part of contemporary practice. Confronted with similar challenges, various PEDs have embraced mechanisms for diversifying the workforce, including sessional medical generalists, higher levels of nursing specialisation and co-located general practices.

4.3.32   In October 2020, there was a surge in ED activity related to increasing mental health and eating disorders workloads as well as a Respiratory Syncytial Virus (RSV) outbreak that exacerbated patient flow in an ED that was highly vulnerable. In addition, a range of clinical risks for PCH were increasingly being shifted from other parts of the hospital to the ED. This was not fully appreciated hospital wide, despite attempts to escalate these concerns.

4.3.33   Patient flow related challenges identified during the Inquiry include:

State-wide:
- Limited state-wide system or coordinated approach to the ED care of children and no networked support across WA for non-tertiary flows.
- Inter-facility transfers are regularly coordinated by the ED and often arrive in the ED for assessment rather than directly to inpatient hospital beds.
- Children with mental health problems or eating disorders are presenting to the ED because there is nowhere else to go.
- Limited and sporadic approach to transfers of children who could have been managed at their local hospital, close to home.

Hospital:
- The patient flow unit (PFU) focuses on flow within the hospital; most admission calls are taken by the Emergency Physicians.
- Children are being reviewed in the ED, coming from home after surgery or for sub-speciality opinion.
- Use of the ED as means of accessing ambulatory paediatric specialist care.
- Transfer of children from outpatient clinics to the ED for admission to wards or for extending ambulatory hours and procedures.
- There are limited options for health services in the community, hospital in the home or rapid access outpatient clinics.
- Increasing levels of access block with insufficient hospital wide responses.
- The ED fulfils a range of functions that could be handled elsewhere, including complex referrals, transfers and retrievals for admission to a ward.
- The delays and limited capacity to review and/or admit patients requiring a bed or consultant decision, leaves children waiting excessive times in the ED before being seen by inpatient teams.

ED:
- There is no agreed demand escalation plan which engages staff throughout the hospital.
- Staffing numbers are not in keeping with the ED models of care.
- Without dedicated staffing of the resuscitation bay, nursing staff are redeployed from other areas, creating delays, disruption and adverse outcomes; such risks are particularly high in the waiting room where children are waiting for care and remain undifferentiated.
- There has been a practice of using ED clinical expert nurses to backfill wards, leaving the ED with less skilled nurses as replacements.
- Nursing shortages in ED meant using senior ED nursing leadership roles, SDNs and CNSs in registered nursing clinical roles; essential ongoing professional development of a specialist ED workforce is then compromised, and clinical supervision reduced for an increasing junior nursing workforce.

4.3.34   The Recommendations of the RCA, along with the ANF 10-point Plan, address a range of improvements and enhancements, many of which deal with the matters identified above **(Appendices B and C).** A substantial number of staffing enhancements (in the ED and beyond), aligned with increases in establishment, are being pursued, with particular emphasis on nursing positions **(Appendices D and E)**. The addition of nursing personnel in triage and the waiting areas, along with enhanced and improved protocols, have been progressed with urgency. These many improvements are acknowledged throughout this Report. The recommendations below are provided to supplement rather than duplicate the RCA and ANF based improvements.

4.3.35   The Executive team response to the recommendations has been comprehensive and supported by the Board and the Department of Health. The substantial investments in additional, nursing and medical, establishment since Aishwarya's death are most welcome **(Appendix E).** Those reforms and enhancements, along with the design and introduction of important initiatives, such as the CAHS Strategic Workforce Plan and the People, Capability and Culture Strategy and Framework, will require continuing commitment and resourcing to ensure implementation, evaluation and sustainability.

Key findings

4.3.36   The history of Princes Margaret Hospital/Perth Children's Hospital has been challenging. Since 2018, there has been a gradual trajectory of improvement in morale, cohesion and engagement. The relocation from PMH to PCH, albeit troubled and delayed, created a new more spacious and attractive patient care environment.

4.3.37   The ED was designed to be substantially bigger, including enhanced triage capability and dedicated waiting areas. The commissioning process signed off on appropriate staffing and operational procedures. However, with experience, the new design proved more challenging to staff and manage. The location of the new ED also added a sense of physical isolation.

4.3.38   The hospital's historic staffing and recruitment strategies, particularly for nursing staff, had relied heavily on national and international recruitment. There was also a disproportionate dependence on casual and temporary contract arrangements. With the emergence of the pandemic, nursing numbers and recruitment options were severely disrupted by both border closures and staff movements to state-wide COVID-19 activities. Further, more demanding clinical practice processes and sick leave thresholds arose from COVID-19 related protocols.

4.3.39   The pressure on ED due to the significant unseasonal rise in presentations from October to December 2020 was not able to be met with a response of sufficient urgency and scale. A further contributing factor was the suboptimal level of contingency resourcing and capacity to respond to unexpected surges in demand.

4.3.40   Junior medical staff reported both challenges and improvements in measures to better support their wellbeing. The training programs and clinical supervision were satisfactory but the inevitable impediments in regular attendance, due to surges in workload, were identified. Importantly, reduced access to leave has affected staff wellbeing.

4.3.41   The Recommendations of the RCA, along with the ANF 10-point Plan, address the matters identified above. A substantial number of staffing enhancements (in the ED and other clinical departments) are being implemented in a staged fashion, with particular emphasis on nursing positions. The addition of nursing personnel in triage and the waiting areas, along with enhanced and improved protocols, have been progressed with urgency. The comprehensive implementation plan will require continuing monitoring and investment to ensure sustainable progress.

Recommendations

10. Embed an appropriately resourced ED nursing capability framework and ED-based education team to facilitate career pathways and continuing education.

11. Minimise the use of casual and temporary contract staff in the continuing development of workforce strategies.

12. Plan and monitor the ED workforce to be contemporary, balanced and adequate across the disciplines and the spectrum of seniority.

13. Expand measures to enable junior medical staff to access leave and continuing education.

14. Enhance the structure, function and governance of the PCH Patient Flow Unit (PFU) to optimally coordinate patient referrals and flow, including out of hours, with no inappropriate requests for ED to manage non-ED patients.

15. Progress strategies to enable early discharge of children, such as criteria-based discharge, to improve predictable daily hospital capacity.

16. Elevate the hospital-wide priority placed on children waiting in ED, who require inpatient beds or consultant review.

4.4 The culture of customer service within the ED in relation to children and their families particularly those of culturally and linguistically diverse (CALD) background

4.4.1 The Inquiry team was presented a mixed picture in the domains of consumer engagement and customer service. A range of initiatives and achievements were documented and discussed at various interviews. Evidence for appropriate recognition of consumer related priorities was presented by the Board, the Executive team and other interviewees. However, substantial gaps were acknowledged at all levels of the organisation.

4.4.2 The documents submitted described a range of consumer surveys, feedback opportunities and complaint mechanisms. The Patient Evaluation of Health Services collated by the Department of Health, explored system wide consumer experience and satisfaction. It included an inpatient module for patients aged 0-15, across the state. The pattern of responses for PCH was steady at mid-range or above with no substantial differences between facilities or longitudinally. The comments were mixed, with praise for the new physical environment at PCH but concerns regarding staffing and communication. An ED module showed comparable steady results for PCH with comments highlighting staffing, communication, signage/wayfinding, and parking concerns. It is noted that in most jurisdictions, children's hospitals lead the state-wide consumer feedback spectrum.

4.4.3 The feedback and complaint loops appeared to be many and varied, all the way from "Ministerials" to ward-based options. The timeliness of responses was also variable but generally considered to be a priority. While there were numerous documents presented to demonstrate courteous correspondence in reply, there was little evidence of further actions to explore or progress the content of such exchanges.

4.4.4 In the wealth of information seeking mechanisms from patients, consumers and the community, there are well acknowledged gaps in identifying aspects of diversity. There has been a commendable focus on Aboriginal populations and a number of measures for access, prioritisation and inclusion are in place. The data regarding families of CALD background is not well documented and monitored across the system. The challenge begins with limited mechanisms of identifying such patients in medical records or survey responses. At the same time, there are acknowledged gaps in cultural competency training and skills. In response to Recommendation 7 of the RCA conducted following the death of Aishwarya, there are measures in place to implement a review of the organisation's ability to respond to CALD healthcare needs at PCH, including the ED. The program and proposed evaluation measures are reported to be on track.

4.4.5 The CALD related sensitivities were raised by the RCA report, as described above and are also mentioned in the section describing matters raised by Aishwarya's family. The Inquiry team and process included important contributions from the nominated family advocate and representative, Suresh Rajan, who is the President of the Ethnic Communities Council of WA. Mr Rajan was also in a good position to comment on opportunities for broader aspects of community inclusion as well as an enhanced utilisation of expertise, such as the one encompassed by the Council, in developing and evaluating health system programs of cultural competence.

4.4.6 The Inquiry heard from a number of consumers and consumer representatives at both local and higher levels. While the participation of consumers in PCH aspects of

governance was identified as visible and formal, there were strong views expressed that it's translation into meaningful engagement and partnership was lacking. Consumer representatives did not feel included in the process of agenda setting, of planning and of relevant decision making. They reported little sense of co-design or of genuine interest in their input. There are important structures for consumer engagement at multiple levels, both within the organisation and across the state, but also gaps in practice at all these levels. Complaints were described as often ineffective and at times potentially counterproductive. The scope for improvement was broad and also highlighted opportunities for the inclusion of CALD consumers and families.

4.4.7   In the ED setting, the adversities relating to staffing, workload and physical design were reinforced. The proposed design changes to visibility, person access and flow, with particular emphasis on the triage and waiting areas, were welcomed. Equally, the progressive increments in staffing were eagerly awaited as was the introduction of the Call and Respond Early (CARE) Call system and related education.

4.4.8   Perceptions that the responses to the tragedy were defensive rather than forward looking were raised by consumer representatives. They feared a missed opportunity to embrace change and improve culture. There was widespread enthusiasm to be invited into the process and to contribute more effectively. The potential to improve partnerships between consumers, the Executive team and the clinical workforce was highly valued. To exemplify, the Executive Director of the WA Health Consumers Council, Pip Brennan, emphasised that their "Person Centred Care" philosophy deliberately encompasses both consumers and health professionals.

4.4.9   Inherent in all good healthcare is the communication, rapport and relationship that develops between the healthcare professional and the patient. For paediatric settings this principle involves both the patient and the parent/carer. In high turnover, very busy and stressed environments, such as a PED, these interactions can be challenging and sensitive. Other parts of this Report highlight the distress of the family in their perceptions of limited compassion and eye contact. The circumstances leading up to the tragic event, resulting in staff exhaustion and loss of motivation are also explained elsewhere in the Report. Morale and capacity were consistently described, by ED staff and their managers, as adversely affected.

4.4.10   In children's healthcare the role of the families as partners in care is paramount. This principle applies across all aspects of healthcare delivery, as well as planning and design. Nothing is more central to this partnership than the understanding of the parental role in recognising changes in their child's behaviour, responsiveness or health status. It is a pivotal component of paediatric training to "listen to the parent" and to appreciate the unique role of the parent in recognising early signs of illness or deterioration.

4.4.11   The introduction of the CARE Call system in the WA inpatient setting is to be applauded. Similar systems across the nation and the world have demonstrated multiple benefits and no evidence of overuse. Unfortunately, the CARE Call system was not introduced in the ED at the same time. Recommendation 4 of the RCA prescribes the development and introduction of such a formal parental escalation model for the ED, including appropriate signage and information in multiple languages. It is understood that the introduction of CARE Call to the ED is expected to improve and accelerate the response of staff to parental concerns. There has been a great deal of progress on this front, including a state-wide expansion of real-time parent and patient escalation mechanisms. Aishwarya's CARE Call is aptly named in the memory of a child whose tragic death has inspired so much soul-searching, reform and improvement.

4.4.12 Documents submitted to the Inquiry described a range of consumer surveys, feedback opportunities and complaint mechanisms. While there was evidence to demonstrate courteous and timely correspondence in reply, there was less information to indicate further actions to explore or progress the content of such exchanges. The consumer comments were mixed, as exemplified by praise for the new physical environment at PCH but concerns regarding staffing and communication, including the ED.

4.4.13 The data regarding families of CALD background is not well documented and monitored across the system. The challenge begins with limited mechanisms of identifying such patients in medical records or survey responses. There was also acknowledgment of gaps in cultural competency training and skills.

4.4.14 Consumers interviewed recognised that PCH had included them in aspects of governance that were visible and formal. However, there were strong views expressed that it's translation into meaningful engagement and partnership was lacking. Consumers did not feel included in the process of agenda setting, of planning, of co-design and of relevant decision making.

4.4.15 Perceptions that the responses to the tragedy were defensive rather than forward looking were raised by consumer representatives. They feared a missed opportunity to embrace change and improve culture. There was widespread enthusiasm to be invited into the process and to contribute more effectively. The implementation of the RCA recommendations was warmly welcomed, with particular emphasis on staffing enhancements and the rollout of the CARE Call system in ED.

4.4.16 In children's healthcare the role of the families as partners in care is paramount. Central to this partnership is the parental role in recognising changes in their child's behaviour, responsiveness or health status. It is an essential component of paediatric clinical care to "listen to the parent" and to appreciate the unique role of the parent in recognising early signs of illness or deterioration. Aishwarya's CARE Call, aptly named in the memory of a child whose tragic death has inspired so much soul-searching, reform and improvement, aligns well with these principles.

Recommendations

17. Consumer engagement and participation be openly explored and progressed, with the intent of productive engagement and meaningful partnership.

18. Partner with consumers in progressing a quality improvement framework.

19. Measures be designed and implemented to identify and monitor health care utilisation by culturally and linguistically diverse (CALD) patients and families.

20. The organisation review and progress its approach to the development, implementation and monitoring of CALD capability strategies, along with commensurate staff competence training programs, enlisting the support of external agencies and expertise.

4.5 Roles and responsibilities of clinicians, management and the executive at PCH, and their escalation of issues to the Child and Adolescent Health Service Board

4.5.1   The health and well-being of children is essential to the future of our society and contributing to children's healthcare is both a privilege and a hugely rewarding calling. The dedicated professionals working in children's hospitals everywhere understand those realities and those at PCH are no exception. The evolution of that culture at PCH has had more than a fair share of challenges, impediments, and transitions over a number of years. However, the Inquiry found a widely held underlying commitment to the healthcare of children to be the essential building block of the road ahead.

4.5.2   The history and the evolution of PMH to PCH and CAHS are discussed elsewhere in the Report. The identified cultural challenges, changes in leadership, adversarial behaviours of some clinicians and managers and related internal tensions and conflicts had been the subject of reviews and proposed reforms. In response to the historic realities and external findings, there have been concerted efforts to build cohesion, heal fissures and encourage clinicians to provide clinical leadership to the organisation. A range of organisational changes, staff surveys and engagement tools, along with staff wellbeing strategies and initiatives were implemented. The longitudinal data, regarding staff engagement and satisfaction, showed heartening, albeit gradual, improvement. The PCH results were often at or above mid-range for the respective WA cohorts. It is worth noting that, in most jurisdictions, children's hospitals lead such survey results. The ED was an active participant in these initiatives and comparisons. There were particular concerns around the low response rates for ED staff (partly situational) but the rising engagement scores were far more encouraging.

4.5.3   Until the events surrounding this tragedy there was a sense of gradual, albeit far from complete, improvement in morale, cohesion and engagement at PCH. While discord between the Executive team and the workforce, as well as between different clinical groups and disciplines persisted to an extent, there was a broadly shared and more optimistic view of the opportunities ahead. One aspect that may have become worse over time is the relative isolation of the ED, in part due to the physical changes and location in the new building and in part due to the increasing challenges of access block and a tendency to depend on the ED to step up in response to a range of clinical and staffing pressures and risks across PCH. The organisational positioning of ED within the large medical service may have also impacted on escalation, where it is one of many departments and not always represented at a hospital and CAHS level. There remained substantial gaps in alignment, staff engagement and satisfaction, along with consumer partnership, as covered elsewhere in this report. The challenges of contingency planning, of workforce preparedness and the capacity for timely surge escalation are also elaborated elsewhere in this report.

The CAHS Board and Executive

4.5.4   The CAHS Board has been very active in supporting this Inquiry through a range of documents and records, followed by discussions, which included input from some prior members. There was a strong sense of commitment, engagement, knowledge and understanding of the issues, with a strong emphasis on learning from this crisis and moving forward. The working relationship between the Board and Executive team appeared tested at times but was managing well in difficult circumstances. There was particular dependence on the skills and experience of the CE, Dr Aresh Anwar. It was

further noted by the Inquiry that, with an extraordinary number of policies, frameworks, guidelines and other documents in place, the capacity to evaluate and monitor implementation and to report trends, tended to be an organisational weakness. The level of operational engagement by the Board inevitably increased in response to the challenges of late 2020, a move further exacerbated by the secondment of the CE in early 2021. The dual reporting lines of the CE to the Board and the Director General of the Department caused the Board some concern.

4.5.5   In the second half of 2016, the WA Health system under the National Health Reform Agreement established Boards of Governance for each Health Service (including CAHS) as separate statutory authorities; and established the Department of Health as the 'System Manager'. At the time, a relatively new CE and Executive team were perceived by medical, nursing and allied health staff as autocratic and non-consultative while working to introduce a new governance structure prior to the move to PCH. In response to staff and community concern, an independent review authorised by the CAHS Board was commissioned (*Child and Adolescent Health Service Review of the morale and engagement of Clinical staff at Princess Margaret Hospital: May 2017*). The findings led to substantial changes and identified a pathway to improving the morale along with the relationship between clinical and executive staff.

4.5.6   In August 2018, Dr Aresh Anwar was appointed as the hospital's CE. Several staff interviewed during this Inquiry spoke of the positive change in the hospital following the adoption of the Review's recommendations and especially the stewardship of the new CE. Staff survey results provide evidence that staff morale had started to improve since the move from PMH. Until late 2020 there was a trajectory of a workforce on the mend. However, the circumstances leading up to this Inquiry indicate an exacerbation of morale issues, superimposed on historic vulnerabilities. To exemplify, the 2021 WA Australian Medical Association survey, taken after the death of Aishwarya, shows senior doctor morale at CAHS to have declined significantly compared with the same survey undertaken in 2019.

4.5.7   Following a long period of instability, the Executive team was seeking to rebuild and create sustainable leadership. However, the number of continuing changes in personnel and roles, the secondment of the CE, the frequency of acting positions and the relative inexperience of some senior players were considered to be serious impediments. In the crisis that followed, surrounding the tragic death of Aishwarya, the gaps identified due to the absence of the established and experienced leader became prominent and the secondment decision was subsequently reversed.

Escalation of concerns regarding clinical risk from Oct 2020

4.5.8   The changes required in the ED models of care to safely manage clinical care in the COVID-19 pandemic were compounded by the workforce challenges. The unprecedented pressures of the COVID-19 pandemic, in both direct and indirect impact on the ED and, in particular, the unseasonal activity trends, came to a head from the 3rd quarter of 2020. These were well recognised national realities, as described in the benchmarking section. The particular pressures of continuing exacerbations in child and adolescent mental health presentations, of the respiratory syncytial virus (RSV) peak and of shifts in access to primary health care were widely acknowledged.

4.5.9   The challenges at PCH appeared disproportionate and of particular concern. The recognition and escalation of the activity pressures and of staffing shortages have been well documented in the materials submitted to the Inquiry. The escalations described encompass middle management, CAHS Executive team, the Board and

the Department, as appropriate. A constant flow of briefings, regular meetings and other communications did not trigger a response of sufficient scale or urgency. Staff safety fears in the face of potential consumer violence prompted the addition of security staff to the ED. COVID-19 also changed ways of safe working and physical proximity in the ED waiting area and at the triage desk.

4.5.10   There appeared to be a disconnect in that the urgency, clarity and severity of the problem became less prominent as the matter escalated through the layers of governance. It is understood that competing priorities do influence relative prominence in the process of escalation. Furthermore, the realities of COVID-19 related workforce shifts across the health system and emphasis on sick leave for the slightest symptoms of COVID-19, as well as the serious obstacles in staff recruitment, exacerbated by the consequent restrictions in travel, were extremely challenging.

4.5.11   Critically, the limited capacity of the hospital's management to respond adequately and in a timely manner to the rising activity demands, workforce concerns and appropriate escalations is recognised as a significant factor in the circumstances preceding this tragic event. In particular, the described exhaustion, loss of morale and anxieties documented by the ED clinicians (nursing and medical) were most profoundly felt at the coalface.

4.5.12   In the weeks that followed Aishwarya's death, the impact of the tragedy combined with extraordinary media, community and political reactions created enormous pressures on the workforce. The anguish and pain of the family were in the public domain. Anger against "all things health system" became channelled into this setting. The health system, the hospital and large numbers of staff at all levels, found themselves unprepared, deeply saddened and devastated.

4.5.13   Historic tensions between the Executive team and the clinical workforce, with particular emphasis on the ED, were rekindled and further fuelled by subsequent developments. The RCA process is described in detail elsewhere. There were diligent attempts to broaden the usual process and ensure strong impartial, external elements, consumer input and Department of Health oversight. There were powerful pressures of urgency and scrutiny, as part of the response pattern described above. The RCA conduct, content and recommendations are generally viewed as having been robust and diligent with a deliberately low threshold for criticism but at the same time forward looking. However, the steps that followed the delivery of the draft report and what were described as deeply troubling deviations from usual process may have, in the minds of many, undermined the intent and benefits of the RCA mechanism for some time to come.

4.5.14   The decision to refer three clinicians (two nursing and one junior medical officer) to the Ahpra has created further tensions and conflict. The criteria and thresholds exercised by the WA health system in making such determinations are not within the Terms of Reference of this Inquiry. What is clearly understood is the enormous schism and polarisation of views this move has generated. For all the reasons described above, the process of healing within and between the ED, whole of PCH, the Executive team and the health system is expected to be protracted. There are signs of reflection and commitment to change at all levels and the recent resourcing commitments are very helpful.

4.5.15   Across Australia and the world, the enormous challenges of the pandemic have exacerbated the inherent tensions and pressures felt by the healthcare workforce. Internationally, one of the highest priorities for children's hospitals has become the recruitment, retention and wellbeing of the paediatric workforce. Expressions such as empathy fatigue, exhaustion and demotivation have reflected broadly felt

sentiments. There is emphasis on the need for mutual support and understanding, along with system-wide responses and investments. Strategies such as "kindness in healthcare", supportive huddles and "humanity in the healthcare workplace" have arisen nationally and beyond, underpinned by "compassionate leadership" initiatives.

4.5.16 Despite the perceptions of despair and the setbacks, the tragic death of Aishwarya has meant across the hospital and beyond, there is an exemplary and positive approach to the implementation of the 11 recommendations of the RCA and the additional 10-point Plan of the ANF. The expertise and commitment of many senior leaders has been mobilised to create the required framework to progress the recommended improvements.

4.5.17 The challenges of sustainable change must not be underestimated. The energy, time and dedication of many will be required, along with appropriate human and material resourcing for this program of reform.

Key findings

4.5.18 Emerging from a challenging history, PCH was on a path of gradual improvement in morale, cohesion and engagement. That progress was severely tested by a range of COVID-19 related challenges, especially the unseasonal increases in ED presentations from late 2020 and then markedly set-back by the circumstances surrounding the tragic death of Aishwarya.

4.5.19 The CAHS Board has supported this Inquiry through a range of documents and records, followed by discussions, which included input from some former Board members. There was a strong sense of commitment, engagement, knowledge and understanding of the issues, with an emphasis on learning and moving forward. The working relationship between the Board and Executive team appeared tested at times but was managing well in difficult circumstances. The secondment of the CE, the frequency of acting positions and the relative inexperience of some senior players were considered to be impediments.

4.5.20 Increased PED activity trends were reported nationally in late 2020. The challenges at PCH appeared disproportionate, based on both staffing availability and activity volume. There were well documented escalations of concern, encompassing middle management, CAHS Executive team, the Board and the Department, as appropriate. A key finding of this Inquiry is an understanding of the multiple factors and impediments that led to a response deemed insufficient in scale and timeliness.

4.5.21 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 RCA report and referrals of clinical staff to Ahpra.

Recommendations

21. The framework, work plan and commitments that underpin the implementation of the RCA recommendations and the ANF 10-point Plan be given the highest priority, be appropriately resourced and be designed to be sustainable.

22. Evaluation and monitoring of agreed indicators be incorporated into all of the implementation plans, including the sepsis pathway and trigger tool, and be supported with sustained resourcing.

23. The program of relationship healing and of restoration of trust be fully embraced and maintained, with not only absolute commitment but also appropriate expertise and resources.

4.6 PCH's clinical incident management process, including an assessment of previous SAC1 incidents to identify potentially preventable factors

4.6.1 The Department provides a comprehensive suite of resources to support clinical incident management that includes a Clinical Incident Management Policy, Clinical Incident Management Guidelines and a Clinical Incident Management Toolkit. These resources provide clarity on definitions, roles and responsibilities, processes, notifications, open disclosure requirements and links to other state-wide policies.

4.6.2 At a local level CAHS has developed a Clinical Incident Management Policy, and a Critical Incident Impact Management (Debrief) Policy that both align with the state-wide policies and guidance. These local policies describe processes and requirements for mandatory reporting, open disclosure, limiting potential and actual consequences, managing risk, and supporting staff after a critical incident. The policies are underpinned by a whole of organisation approach and 'no-blame' reporting culture.

4.6.3 CAHS policy defines a SAC1 as including 'all clinical incidents and near misses where serious harm or death is or could be specifically caused by health care rather than the patient's / client's underlying condition or illness.' It is worth noting that some interviewees identified that CAHS often has a lower threshold for inclusion of an incident as a SAC 1, and the Inquiry supports this approach which allows for greater review and consideration of near misses. PCH's approach to patient safety requires staff to report cases not only associated with death and serious harm, but also those related to near misses, minor and moderate harm. The Department encourages sharing of the RCA's lessons learnt within and between hospitals including through the publication of safety alerts. In addition, WA health and its hospitals have publicly reported on SAC 1 incidents, initially through the publication of "Your safety in our hands" since 2012 and more recently, through individual health service boards. Proactive approaches to clinical incidents are required to ensure patient safety and should be encouraged.

4.6.4 According to CAHS policy all SAC1 incidents must have a RCA investigation completed within 28 working days, and recommendations implemented within six months of the finalised investigation report. A small RCA panel is required to be stood up within 48 hours, and the report provided to the Executive within 28 working days for their consideration and minor review. Following this it is generally accepted by the Executive team, and then provided to WA Health as the system manager.

4.6.5 The purpose of a RCA is to identify underlying or systemic issues that may have contributed to an incident, rather than looking for the immediate causes of the incident. It is focused on understanding why the incident happened and what led to it happening. Correcting only an immediate cause of an incident may eliminate the symptom, but not the problem itself if there are consistent underlying or systemic issues. The RCA process is established as a learning mechanism for organisations based on a just-culture and a focus on systems improvement rather than individual improvement, which can be addressed through other means.

4.6.6 In addition to RCA processes, CAHS has a single hospital-wide Mortality and Morbidity Review Committee that aims to review every death within the service. Interviewees indicated the depth of the review by this committee reflects the complexity of the circumstances and is generally determined on a case by case basis. Review of deaths by this committee are classified according to WA Health guidelines

based on preventability, and recommendations are made and communicated to the Executive team and involved clinicians. This Committee does not review morbidity.

4.6.7   Interviewees stated that there is no mechanism for driving compliance with recommendations from the Mortality and Morbidity Review Committee. It is also unclear, from both documentation and interviews, how recommendations from this committee, and their implementation, are monitored or reviewed over time.

Learning from clinical incidents

4.6.8   CAHS policies on clinical incident management provide limited detail on the mechanisms for communicating the outcomes of clinical review. When discussed during interviews, multiple avenues were described to communicate clinical incident review findings such as emailing the department involved, providing information to the Safe Systems of Practice Committee, including a summary in the safety and quality newsletter, and others. However, the majority of mechanisms described appeared to be ad hoc, and communication mechanisms varied substantially. There did not seem to be a clear safety and quality framework for reporting and responding to clinical review, including regular interdisciplinary Morbidity and Mortality Meetings in each clinical unit that have a reporting line to the Safe Systems of Practice Committee. There appeared to be further siloing of committees for implementation of accreditation requirements, and limited reporting to hospital staff of lessons learnt from clinical incidents.

4.6.9   Overall, CAHS may benefit from considering a safety and quality framework for reporting and responding to clinical review which could include regularly interdisciplinary clinical unit level Morbidity and Mortality meetings, greater integration of committees considering safety and quality issues, improved follow up, support and review of effectiveness of implementation of recommendations beyond the six month period identified within the SAC1 RCA process.

SAC1 review themes

4.6.10   From 1 January 2020 to 3 April 2021 there were 24 confirmed SAC1 incidents with RCA investigations and reports. The SAC1 RCA reports for these investigations referred to a range of different types of issues such as infection control; medication error; incorrect procedure; delay in treatment; and gaps in recognition of symptoms and escalation of care.

4.6.11   Sadly, three of these 24 incidents involved the death of a child. All three of these cases concerned neonates, two of whom were pre-term. Nine of the incidents involved serious harm, and twelve incidents involved minor to moderate harm to patients.

4.6.12   It is worth noting that six of the 24 incidents were related to behavioural issues including self-harm, eating disorders and suicide attempts. This aligns with the concerns raised by many interviewees about the increasing mental health presentations to the hospital (and ED) and the pressure reportedly created by limited availability of appropriate community-based, early-intervention mental health services.

4.6.13   Nine of the 24 incidents directly referenced either sepsis or healthcare associated infections within the RCA reports. Three of these children presented to the ED with sepsis; two children had delayed identification of sepsis or delay in treatment within the ED that resulted in moderate to serious harm, and one child presented with a central line infection that resulted in moderate harm. The RCA report for this latter

case noted that in this incident sepsis was identified and managed quickly and appropriately on presentation to the ED.

4.6.14   The RCA reports reviewed by the Inquiry team included an average of 3-4 recommendations per incident. However, it was noted that those that involved reference to sepsis generally tended to include a higher number of recommendations (4-8 recommendations).

4.6.15   Recommendations included in the RCA reports primarily related to review and improvement of guidelines, policies and processes that related to clinical aspects of the incident including recognising and responding to sepsis; communication processes; open disclosure processes; and in some cases staffing availability and models of care. The type of recommendations proposed reflected the key themes identified in the SAC1's and it appeared that the majority of recommendations were on track or had been completed within the timeframe specified. Some recommendations were completed outside the six months prescribed timeframe, particularly those requiring coordinated action between organisations or substantive consultation. There were no follow-up or evaluation data provided.

4.6.16   A sepsis clinical guideline had been developed at PCH, after unsuccessful attempts at a national collaborative in 2017. The Inquiry panel heard that following the three cases of sepsis in the ED a group of clinicians with specific expertise and longstanding interest in improving the early identification of sepsis were convened to work on a sepsis pathway for the hospital. This work was then brought together with piloting and refinement of the PARROT chart within PCH. The sepsis tools were linked to the third iteration of the PARROT chart. At the time of Aishwarya's death the third edition of the PARROT chart (including link to a sepsis pathway) was very close to implementation, and it has since been put into practice.

4.6.17   The challenges in the timely recognition and management of sepsis are recognised nationally and internationally. In June 2020, the Australian Commission on Safety and Quality in Health Care was engaged by the Australian Government Department of Health to lead and coordinate the National Sepsis Program, which aims to:
- Improve the recognition of sepsis in all settings (primary, subacute, acute)
- Provide clinicians with nationally agreed clinical guidance materials for sepsis
- Strengthen the comprehensive care planning process for sepsis survivors.

Key components of the National Sepsis program include: revising the Antimicrobial Stewardship Clinical Care Standard to emphasise the importance of prompt treatment of severe sepsis; undertaking a literature review on evidence for triggers and tools for identifying sepsis; conducting a medical record review of sepsis patients to inform improvements to coding; developing a Sepsis Clinical Care Standard; conducting research to inform understanding of the need for models of care for sepsis survivors; and raising awareness of the need for early identification of sepsis.

Key findings

4.6.18   PCH and CAHS have a range of policies to guide and describe clinical incident management processes.

4.6.19   Communication of outcomes, reporting and responding to the findings of clinical review processes appeared to be quite varied within PCH. A range of communication and implementation mechanisms and strategies were identified, but there appeared to be a diversity of approaches that were not always integrated and coordinated. PCH may benefit from a clear safety and quality framework for reporting and responding to clinical review processes.

4.6.20   There appear to be some limitations to the current model for the PCH Mortality and Morbidity Review Committee. Interviewees described a single hospital-wide committee that only reviews mortality (not morbidity), possesses limited levers for implementation of committee recommendations, and appeared variably connected to other safety and quality improvement processes.

4.6.21   Between 1 January 2020 and 3 April 2021, there were 24 RCA reviews of SAC1 incidents. Of these, nine involved sepsis or healthcare associated infection. Three of those cases occurred within the ED, none of whom died. The first two of those cases involved delayed identification of sepsis, in the third case, sepsis appeared to have been appropriately identified and managed.

Recommendation

24. Embed a learning culture that ensures findings and outcomes of reviews and reports are communicated widely and treated as an ongoing opportunity to reflect and improve systems, processes and activities.

4.7 PCH's clinical risk management processes

4.7.1   CAHS and WA Health provide a range of policies, processes and guidelines related to risk management. CAHS's Risk Management Policy describes the process for identifying, mitigating and managing all types of risks within the organisation. This policy appears to align with, and is informed by, WA Health Risk Management Policy and Australian and New Zealand Standards Risk Management Principles and Guidelines.

4.7.2   It is noted, that CAHS does not appear to have a separate policy or guideline on clinical risk management, and the overarching CAHS Risk Management Policy has limited reference to clinical risk. The policy is written to be applicable to all risks and does not appear to provide information on where clinical risks may differ from corporate risks.

4.7.3   WA Health Clinical Risk Management Guideline was provided by WA Health as a relevant best practice policy in this area. Interviewees from CAHS and PCH discussed the processes of identifying clinical risks for patients and patient outcomes, including the particular risks relevant to the ED. The Guideline requires health services adapt processes locally, including through their own clinical risk management framework. The focus on clinical risk management appears to be expressed through safety and quality improvement activities including requirements for the preparation of accreditation, which is then absorbed into a general risk management framework managed by CAHS Executive team.

4.7.4   The CAHS policy clearly describes responsibilities, including ownership of risks. The ownership of all risks resides with CAHS Executives at all times, responsibility for medium to low risks can be delegated to Directors – but accountability remains with the CAHS Executive team.

4.7.5   The policy states that the CAHS Operational Committee is the sole source referrer to the CAHS Executive team of all clinical risks. However, it is not sufficiently clear from the documentation (including description of roles and responsibilities) what the pathway is for escalating a clinical risk identified within a department (beyond documentation in a risk register), and consideration of the implications of that risk for the whole organisation. The pathway may vary for different departments, and for different types of risk, but it was apparent during interviews that there was a degree of confusion and frustration within the ED about how to escalate concerns about clinical risks and then remain aware and engaged with the progress of any action being taken.

Pathways for escalating ED concerns

4.7.6   The two ED Heads of Department report to the Medical Service Unit (4) Co-Directors, who in turn report to the Executive Director of Medical Services (as part of the Executive team). The Co-Directors of the Medical Service Unit are responsible for up to 23 departments, wards or groupings. The Medical Service Unit holds quarterly meetings to discuss issues across the Unit. It was noted by the Inquiry team that the ED does not appear to have direct representation within safety and quality, and other similar hospital-wide committees.

4.7.7   In addition, some issues specific to nursing may be escalated through the Executive Director of Nursing, who does not have direct line management for the ED but is responsible for coordinating nursing services.

4.7.8   The challenges of appropriate ED representation and access in the organisational structure were apparent. The relative size and complexity of the Medical Service Unit (4) may be a factor. It is noted by the Inquiry team that comparable organisations have found value in a separate Division or Service Unit encompassing Critical Care components, such as ICU, ED, Cardiac (medical and surgical) services and the like.

4.7.9   Interviewees identified a plethora of committees and advisory groups with an interest in various aspects of safety and quality, and in mitigating clinical risk. Comments were made on the varying degrees of connectedness and integration of the committees mentioned.

ED concerns about clinical risk

4.7.10 ED staff and management were reported to have raised concerns regarding the pressures on the ED, particularly relating to:
- The configuration of the ED waiting room.
- Nursing workforce, including prioritising nursing staff to inpatient wards over ED.
- Staff vacancies, staff skillsets.
- Prolonged stays in ED for admitted patients waiting for either a bed or review.
- Perception that PCH's clinical risks were being moved to ED.
- Rising ED presentations with no alternative pathways to care.

4.7.11 A number of interviewees, from both within and external to the ED, identified frustration at their ability to escalate consideration of these risks to clinical care within the organisation. Some interviewees described multiple attempts at formal and informal meetings with senior and Executive staff, attempts at progression through committees and, after other avenues were felt to be exhausted, making direct contact with the Executive team and Board.

4.7.12 In interviews it appeared that these concerns were recognised by both the Acting CE and CE in the lead up to the death of Aishwarya, and it was reported that various avenues were being explored. However, there was also a degree of frustration at the perceived lack of progress in responding to the concerns, and views that the weight of these concerns were not being translated. Issues such as changes to the Executive team and various acting arrangements, the need to progress concerns through multiple channels, challenges in finding and engaging staff during COVID-19, nursing recruitment policy that limited the candidate pool, and other factors may have contributed to this perception of a slow response.

Key findings

4.7.13 The Department of Health has developed and implemented a comprehensive safety system which aims to protect the people of Western Australia from harm related to healthcare. As part of its safety program, the Department of Health has published Clinical Risk Management Guidelines which provide guidance to health service providers.

4.7.14 PCH CAHS have a policy framework for risk management, with a focus on identification, prevention and mitigation of organisational risks.

4.7.15 PCH does not appear to have a separate policy or guideline on clinical risk management, and the overarching CAHS Risk Management Policy has limited reference to clinical risk. PCH should implement the Department of Health's Clinical Risk Management Guidelines.

4.7.16 It is unclear, from documentation and comments from interviewees, what the most relevant and appropriate pathways are for staff wishing to raise and/or escalate concerns about clinical risks, and to support consideration of these risks at an organisational level.
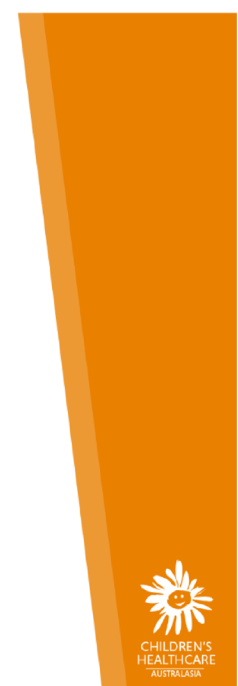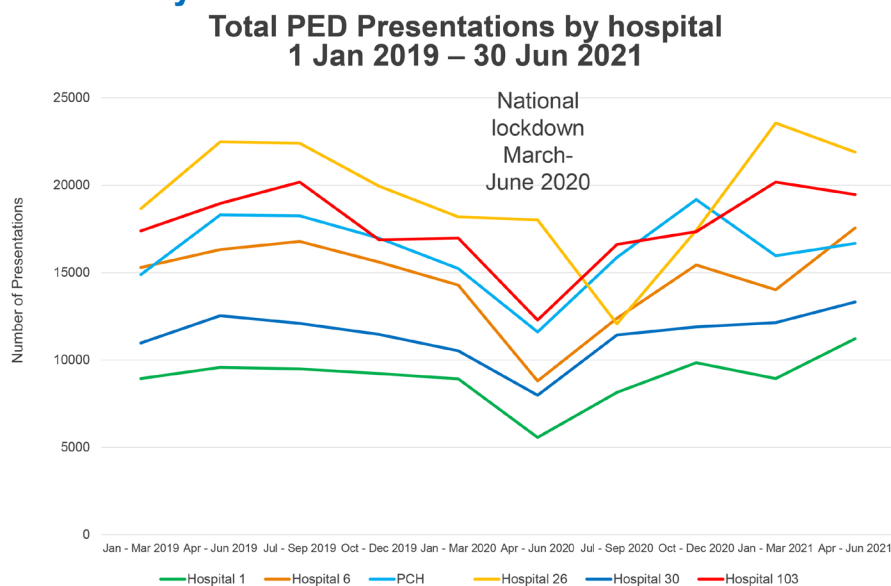
Recommendations

25. Integrate and prioritise clinical risk in the risk management policy and reinforce the escalation pathways for departments and services.

26. Review the organisational and committee structures, aiming to streamline pathways for progression / escalation of clinical and organisational risks, with appropriate engagement of the ED and other service departments.

4.8 The performance of PCH in relation to safety and quality measures as compared to national peers

4.8.1   PCH and, in particular the ED, has a track record of robust participation in benchmarking opportunities at WA state level, at the national Health Roundtable and as part of CHA. Each of those domains has had some inherent limitations in valid comparisons but the cumulative data and trends indicate a satisfactory pattern with PCH generally performing at or above the average for the respective cohorts. It is noteworthy that PCH has often performed better than peers in the measures of ED waiting times, of ED average length of stay (ALOS), and of ED admission rates. Much of this reflects the historic WA leadership in the introduction, emphasis and monitoring of the "4-hour rule" (2009) and the defined WA Emergency Access Target (WEAT, January 2016) performance for ED's.

4.8.2   There is agreement across health systems that the most valid benchmarking peer group for children's hospitals are comparable tertiary paediatric facilities (similar children's hospitals) in other jurisdictions. To that effect CHA has a particular and important role across children's health services in Australia and New Zealand. The national trends in activity across the CHA peer group of six PEDs in children's hospitals have been relatively consistent and well aligned over the years of benchmarking activity. This record has also allowed local initiatives, such as the WEAT performance emphasis, to manifest in both comparative and longitudinal measures.

4.8.3   The COVID-19 pandemic has had a range of profound, direct and indirect impacts on the performance of PED's. Continued and increasing challenges in child and adolescent mental health, reductions in access to primary health care and the extraordinary wave of respiratory syncytial virus (RSV) presentations exemplify some of these mechanisms. The CHA activity reports reflect the relatively consistent patterns of reductions in ED presentations across all six facilities in the PED benchmarking cohort, in the second quarter of 2020 compared with the same quarter of 2019, and then a sharp and sustained rise in presentations until mid-2021 (with minor variations and fluctuations). This unprecedented unseasonal rise in activity through the spring and summer of 2020 and into the autumn months (albeit with a small and transient late summer dip) has created widespread concerns across the nation **(Figure 1)**.

Figure 1. Total PED presentations by hospital taken from *Children's Healthcare Australasia PED Activity and Staffing Benchmarks 1 January 2019 – 30 June 2021*

4.8.4   Directors of PED's across all children's hospitals have expressed their consensus warnings regarding the risks associated with the activity patterns, the staffing pressures and the inadequacy of contingency responses. With the whole of the health system under unprecedented pressures, the historic tendencies to rely on PED's in children's hospitals as buffers and default options for many and varied clinical challenges or surges, became hugely exacerbated and a source of substantial risks. The ultimate bottle neck of such back pressures becomes the ED waiting room, perceived as "the only elastic area in a hospital". In a national collaborative process, the Directors of PED's have described a range of measures to address these troubling trends, requiring not only a "whole of hospital" but also a "whole of health system" perspective. It is noted that responses to those recommendations are being progressed by children's hospitals across multiple jurisdictions.

4.8.5   The PCH trends have mirrored and often exceed the national patterns. During the last quarter of 2020, the PCH ED became the single busiest PED in the nation, contrary to its usual status in mid-cohort **(Figure 1)**. That singular position was transient but the overall patterns of extraordinary activity have not abated. At the same time the historic PCH lead position in ED waiting times and ALOS was lost but partially recovered in 2021.

4.8.6   The data on PED nursing workforce and on ratios seeking to represent relative nursing workloads have been historically inconsistent across the various benchmarking platforms. The Nursing Hours per Patient Presentation (NHpPP) methodology is monitored across WA ED's. In January 2021, a variance from workload targets was recognised at PCH and reported to the Department of Health. As described in other parts of this report, the capacity for timely response to such trends was limited by COVID-19 related recruiting obstacles. However, the historic overdependence on a casual nursing pool and the diminution of that resource with the pandemic related jobs growth, acted to further exacerbate the problem.

4.8.7   In recognition of the challenges associated with accurate workforce comparison across the state jurisdictions, CHA has continued to update its methodology and has provided a current, purpose specific report during the Inquiry. Following a mapping

process to ensure meaningful comparisons of different nursing roles across jurisdictions, an agreed and consistent mechanism of workforce data collection, using the hospital payroll systems, was determined. The inclusion of a measure of "PED activity vs Nursing FTE" is of particular relevance. The CHA data indicate that PCH has tended to show the highest numbers of "PED presentations per nursing FTE" for the entire cohort, over the past two years **(Figure 2)**. In the absence of this level of peer-group benchmarking, such findings would not have been recognised. Importantly, with the described, extraordinary rise in activity in mid to late 2020, the gap in relative nursing workforce between PCH and other benchmarking peers had further widened **(Figure 2)**. Some subsequent improvements in these metrics are noted in mid-2021.

Figure 2. PED presentations per nursing FTE taken from *Children's Healthcare Australasia PED Activity and Staffing Benchmarks 1 January 2019 – 30 June 2021*
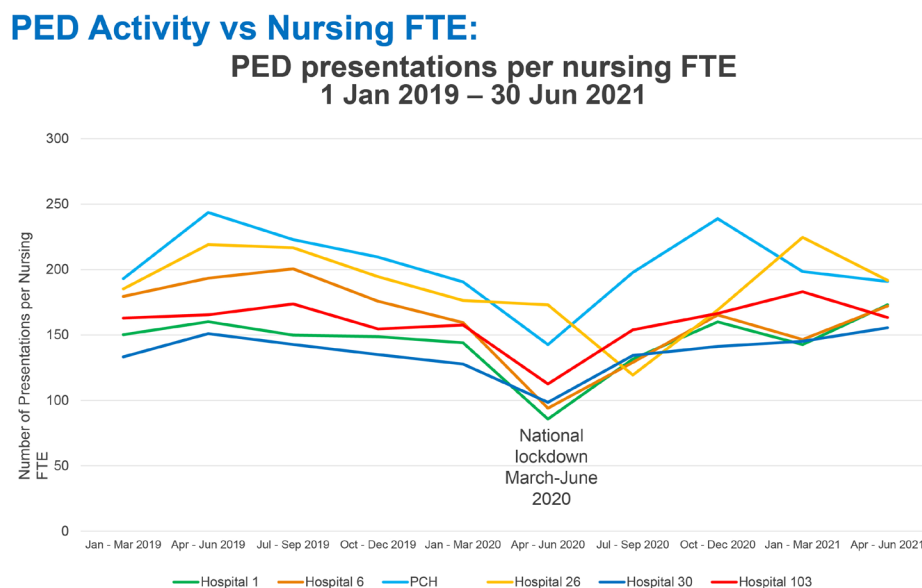

4.8.8   The analyses of benchmarking and other data by the CAHS leadership have highlighted the need for ED staffing enhancements across not only nursing but also senior and junior medical clinicians. A range of substantial commitments, from CAHS through to WA government, have been made and documented, all the way up to the recently announced State Budget **(Appendix D and E)**. These enhancements are detailed elsewhere, along with other investments which will further benefit the capacity, the flow and the consequent safety of the ED. Importantly, to quote an Executive briefing note: "The revised ED staffing model will be subject to continued review and improvements in collaboration with ED staff". The Inquiry team applaud this perspective, along with all recent commitments, and encourage their progression, despite the anticipated challenges of sustainability and the contested nature of budgets.

4.8.9   The most recent Children's Hospitals Comparative Performance Quarterly Report, released by CHA (encompassing the period of April to June 2021), documents the PCH hospital-wide and ED-specific benchmarking performance against the average for the peer group. While ED presentations increased (compared to the previous quarter) in both number and acuity, along with PCH-wide separations, the ED LOS performance improved, both overall and in all but one ATS category. Quality measures such as "did-not-wait to be attended", admission rates and unplanned re-presentations to ED (within 48 hours), also compare favourably to peers. Equally, key

measures of hospital-wide safety and quality at PCH, such as Hospital-Acquired Complications (HACs), both overall and across all specific line items, are exemplary, as they had often been historically.

4.8.10   The broader aspects of collaboration and benchmarking between children's hospitals across the nation, reveal shared challenges in the optimal relationships with other paediatric facilities, mostly located in general hospitals. The magnet effect of children's hospitals on communities beyond their natural non-tertiary catchment and the particular impact of such consumer behaviours on the PED are well recognised. In most jurisdictions, the overarching or purchasing authorities (usually a state department or ministry of health) have recognised a role for formal paediatric networks, standardisation of practice guidance, expectations of local health service responsibility and some measures of compliance. The goal of appropriate care as close to home as possible, with well-defined tiered networks and escalation pathways, is optimal for patient access, given the reality that paediatric specialty expertise is highly centralised. Further, most jurisdictions have also moved to implement integrated electronic medical records as a means of supporting both point of care and more complex longer-term aspects of healthcare.

Key findings

4.8.11   Benchmarking against various state and national cohorts is well established at PCH. A key benchmarking peer group for children's hospitals is a cohort of comparable tertiary paediatric facilities in other jurisdictions. CHA provides that platform and has documented that national trends in activity across the peer group of six PEDs in children's hospitals have been relatively consistent and well aligned over the years.

4.8.12   PCH has often performed better than peers in the measures of ED waiting times, of ED average length of stay (ALOS), and of ED admission rates. Much of this reflects the historic WA leadership in the introduction, emphasis and monitoring of the "4-hour rule" (2009) and the defined WA Emergency Access Target (WEAT, January 2016) performance for ED's.

4.8.13   The CHA activity reports reflect relatively consistent patterns of reductions in ED presentations across all peer group facilities in the second quarter of 2020 compared with the same quarter of 2019, and then a sharp and sustained rise in presentations until mid-2021. Directors of PED's across all children's hospitals have expressed their consensus warnings regarding the risks associated with the activity patterns, the staffing pressures and the inadequacy of contingency responses, with particular emphasis on ED waiting rooms.

4.8.14   The PCH trends have mirrored and often exceed the national patterns. During the last quarter of 2020, the PCH ED transiently became the single busiest PED in the nation. Of particular note, CHA data indicate that PCH has tended to show the highest numbers of "PED presentations per nursing FTE" for the entire cohort, over the past two years. With the extraordinary rise in activity in late 2020, the gap in relative nursing workforce between PCH and other benchmarking peers had further widened.

4.8.15   The WA Government made significant investments in hospitals, health and mental health services with a $1.9 billion boost in the 2021-22 State Budget to help address the unprecedented demand on WA's health and mental health system. The funding boost means 22 additional beds and 278 additional staff across CAHS (**Appendix E**).

4.8.16   The magnet effect of children's hospitals on communities beyond their natural non-tertiary catchment and the particular impact of such consumer behaviours on the PED

are well recognised. In contrast to the WA situation, in most jurisdictions the systems managers have implemented formal, tiered paediatric networks, standardisation of practice guidance and expectations of local health service responsibility, in order to facilitate appropriate care as close to home as possible.

Recommendations

27. The benefits of sharing and collaboration with other children's hospitals continue to receive appropriate emphasis, particularly in relation to ED and workforce challenges.

28. Reforms identified to enhance, improve and sustain the workforce include regular sharing of information with peers across WA and the nation.

29. CAHS engage the Department of Health in seeking to establish formal networks across children's healthcare in metropolitan and regional WA, with the aim of improving access, encouraging standardisation of care, supporting community confidence in local facilities and managing activity flows.

30. Engage peer-group children's hospitals in response to the national PED trends, warnings and proposed actions identified through the collaborative efforts of the Directors of Australian PEDs.

5. Summary of Recommendations

The following recommendations result from the findings of the Inquiry and are intended to be read in conjunction with the recommendations of the RCA undertaken in response to Aishwarya's death.

1. The Executive team and senior clinicians approach the family in a process of open disclosure and seek to engage them in a healing dialogue.

2. In acknowledging the devastating tragedy that was the death of Aishwarya, the health system and CAHS engage the family in implementing recommendations and maintaining learnings, improvements and reforms.

3. Expand the PCH capacity to train and support ED staff in communication, partnering with consumers and customer relations.

4. The importance of the parent's extraordinary role in the recognition of deterioration, or indeed any change in the behaviour or health status of their child, be reinforced and embedded throughout all clinical and administrative protocols and training curricula.

5. The Call and Respond Early (CARE) Call system, as adapted to ED settings, be progressed, evaluated, sustained and rolled out across multiple WA locations, as part of Aishwarya's CARE Call, led by the Department.

6. The Executive team engage the Board and the health system clinicians and managers in their shared understanding of the purpose of the RCA, its role within the hospital's safety program and its limitations as an investigative tool.

7. The hospital's RCA policy and procedures include guidance that is issued to both RCA team members and interviewees that clearly outlines their roles, responsibilities, the confidentiality extended to the RCA process, together with how the RCA findings will be used.

8. A consumer-friendly document should explain the purpose and format of the RCA process and clarify how the patient and their family may be involved in the RCA process, the opportunity to be interviewed and when and in what form they will receive the report.

9. The WA Department of Health supports the implementation of the recommendations of the draft Clinical Excellence Division *Review of the Guidance for Procedures Associated with Notification of Reportable Conduct* to provide a clearer more cohesive policy framework for managing complaints and concerns about clinicians.

10. Embed an appropriately resourced ED nursing capability framework and ED-based education team to facilitate career pathways and continuing education.

11. Minimise the use of casual and temporary contract staff in the continuing development of workforce strategies.

12. Plan and monitor the ED workforce to be contemporary, balanced and adequate across the disciplines and the spectrum of seniority.

13. Expand measures to enable junior medical staff to access leave and continuing education.

14. Enhance the structure, function and governance of the PCH Patient Flow Unit (PFU) to optimally coordinate patient referrals and flow, including out of hours, with no inappropriate requests for ED to manage non-ED patients.

15. Progress strategies to enable early discharge of children, such as criteria-based discharge, to improve predictable daily hospital capacity.

16. Elevate the hospital-wide priority placed on children waiting in ED, who require inpatient beds or consultant review.

17. Consumer engagement and participation be openly explored and progressed, with the intent of productive engagement and meaningful partnership.

18. Partner with consumers in progressing a quality improvement framework.

19. Measures be designed and implemented to identify and monitor health care utilisation by CALD patients and families.

20. The organisation review and progress its approach to the development, implementation and monitoring of CALD capability strategies, along with commensurate staff competence training programs, enlisting the support of external agencies and expertise.

21. The framework, work plan and commitments that underpin the implementation of the RCA recommendations and the ANF 10-point Plan be given the highest priority, be appropriately resourced and be designed to be sustainable.

22. Evaluation and monitoring of agreed indicators be incorporated into all of the implementation plans, including the sepsis pathway and trigger tool, and be supported with sustained resourcing.

23. The program of relationship healing and of restoration of trust be fully embraced and maintained, with not only absolute commitment but also appropriate expertise and resources.

24. Embed a learning culture that ensures findings and outcomes of reviews and reports are communicated widely and treated as an ongoing opportunity to reflect and improve systems, processes and activities.

25. Integrate and prioritise clinical risk in the risk management policy and reinforce the escalation pathways for departments and services.

26. Review the organisational and committee structures, aiming to streamline pathways for progression / escalation of clinical and organisational risks, with appropriate engagement of the ED and other service departments.

27. The benefits of sharing and collaboration with other children's hospitals continue to receive appropriate emphasis, particularly in relation to ED and workforce challenges.

28. Reforms identified to enhance, improve and sustain the workforce include regular sharing of information with peers across WA and the nation.

29. CAHS engage the Department of Health in seeking to establish formal networks across children's healthcare in metropolitan and regional WA, with the aim of improving access, encouraging standardisation of care, supporting community confidence in local facilities and managing activity flows.

30. Engage peer-group children's hospitals in response to the national PED trends, warnings and proposed actions identified through the collaborative efforts of the Directors of Australian PEDs.

6. Glossary

Term	Definition
Access block	Access block is the situation where emergency department patients who have been admitted and need a hospital bed are delayed from leaving the emergency department for more than eight hours due to a lack of inpatient bed capacity.
Ahpra	The Australian Health Practitioners Regulation Agency (Ahpra) is the national organisation responsible for implementing the National Registration and Accreditation Scheme across Australia.
ACEM	The Australasian College of Emergency Medicine (ACEM) is the not-for-profit organisation responsible for training emergency physicians and advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand.
Average length of stay (ALOS)	Average time spent in hospital for a specific condition.
Australian Triage Scale (ATS)	The ATS is a clinical tool used to establish the maximum waiting time for medical assessment and treatment of a patient.
Benchmarking	Performance data comparison.
CAHS	Child and Adolescent Health Service (CAHS) is made up of Neonatology, Community Health, Child and Adolescent Mental Health Services and Perth Children's Hospital.
CALD	Refers to people from culturally and linguistically diverse (CALD) backgrounds.
Call and Respond Early (CARE) Call	The CARE Call is an escalation tool for patients, their families and carers to notify staff if a patient is getting sicker or if patients and their carers don't feel their concerns are being heard.
CE	Chief Executive
Clinical governance	An integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of safe, effective and high-quality services. Clinical governance systems provide confidence to the community and the healthcare organisation that systems are in place to deliver safe and high quality health care.
Clinical incident	An event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or consumer; or a complaint, loss or damage. An incident may also be a near miss.

Term	Definition
Clinical risk	Combination of the severity of harm to a patient and the likelihood of occurrence of that harm.
CNS	Clinical Nurse Specialist
COVID-19	Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus.
ED	An emergency department (ED) is part of a hospital that provides 24-hour emergency care to patients who need urgent medical attention.
ED operational flow	Refers to the movement of patients, information or equipment within the ED and from the ED to other areas of the hospital.
EMR	Electronic medical record.
EDIS	Emergency Department Information System (EDIS) supports workflow efficiency and patient safety by eliminating drop-down menus, unnecessary screens, confusing dialogue boxes, and excessive keystroked.
Emergency Department Short Stay Unit	Inpatient units, managed by the ED staff. Designated and designed for the short term (generally up to 24 hours).
Group A Streptococcus (GAS) *or* streptococcus pyogenes	Bacteria called group A Streptococcus (GAS) can cause many different infections. These infections range from minor illnesses to very serious and deadly diseases.
Impetigo	A bacterial infection of the skin that is most common in young children.
Models of care	A multifaceted concept which broadly defines the way health services are delivered. It outlines best practice patient care through a set of service principles.
Morbidity and mortality meetings	Multidisciplinary meetings to review the quality of care being provided to patients from a department, a speciality profession or the whole facility.
NEAT	The National Emergency Access Target (NEAT) stipulates that a pre-determined proportion of patients should be admitted, discharged or transferred from an ED within 4 hours of presentation.
Neonatology	The branch of medicine concerned with the treatment and care of newborn babies.
Nursing Hours per Patient Presentation (NHpPP)	A model that ensures flexibility in the supply of nursing and/or midwifery hours to meet the variable demands of patient care, with the recommendation of minimum safe staffing levels. It also measures and reports on the direct clinical care hours required and provided by nurses and midwives.

Term	Definition
Oxygen saturation	Oxygen saturation is the fraction of oxygen-saturated hemoglobin relative to total hemoglobin in the blood. The human body requires and regulates a very precise and specific balance of oxygen in the blood. Normal arterial blood oxygen saturation levels in humans are 95–100 percent.
Paediatric Acute Recognition and Response Observation Tool (PARROT)	A chart that supports accurate and timely recognition of clinical deterioration, and prompts action when deterioration is observed.
Patient Evaluation of Health Services (PEHS)	A patient experience survey used by WA Health.
Patient flow	The ability of the healthcare system to serve patients quickly and efficiently as they move through stages of care.
Patient flow model	Models of care designed to improve patient flow.
PED	Paediatric emergency department
Person-centred care	An approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients. Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care. Also known as patient-centred care or consumer-centred care.
PCH	Perth Children's Hospital
Pharyngitis	A sore throat, also called a throat infection or pharyngitis, is a painful inflammation of the back part of the throat (pharynx).
PMH	Princess Margaret Hospital
Respiratory syncytial virus (RSV)	Respiratory syncytial virus, also called human respiratory syncytial virus and human orthopneumovirus, is a very common, contagious virus that causes infections of the respiratory tract.
Root Cause Analysis (RCA)	The process of discovering the root causes of problems in order to identify appropriate solutions.
SAC 1	Severity Assessment Code (SAC) 1
SAC 1 clinical Incident	A clinical incident that has or could have (near miss), caused serious harm or death; and which is attributed to health care

Term	Definition
	provision (or lack thereof) rather than the patient's underlying condition or illness.
SAC 1 clinical Incident Investigation Report	The form used to report a SAC 1 clinical incidents.
SDN	Staff Development Nurse
Sepsis	Life-threatening organ dysfunction caused by a dysregulated host response to infection.
WEAT	The Western Australian Emergency Access Target (WEAT) requires that 90 percent of all patients presenting to a public hospital ED will be seen and admitted, transferred or discharged within four hours.

Appendix A: Call for documentation

Call for documentation relating to the Independent Inquiry into Perth Children's Hospital

The investigators undertaking the Independent Inquiry into Perth Children's Hospital (PCH) following the death of Aishwarya Aswath on 3 April 2021, request the following documentary evidence to assist with the Inquiry. Documentary evidence includes paper-based records, electronic records on computers or other devices including emails, text messages, video or audio recordings, social media and browser histories of server logs.

The Inquiry (per the Terms of Reference) will investigate:

- Any matters raised by the Aswath family in relation to the care and treatment of their daughter;
- The conduct of the Root Cause Analysis (RCA), any issues identified by the RCA, and the recommendations made on the basis of those findings;
- The Emergency Department's staffing, patient flow model, clinical supervision and education programs (as recommended in the RCA);
- The culture of customer service within the Emergency Department in relation to children and their families particularly those of culturally and linguistically diverse (CALD) backgrounds;
- Roles and responsibilities of clinicians, management and the executive at PCH, and their escalation of issues to the Child and Adolescent Health Service Board;
- PCH's clinical incident management processes, including an assessment of previous SAC1 incidents to identify potentially preventable factors;
- PCH's clinical risk management processes;
- The performance of PCH in relation to safety and quality measures as compared to national peers.

The Inquiry team will rely on the provision of all documentary evidence relating to the terms of reference for the above Inquiry, rather than conducting a search for all documentary evidence related to this matter.

The documentary evidence should be named with appropriate identifying information, and be included in an itemised list and provided to the investigators.

The list below is indicative of all relevant documentary evidence which should be provided to the Inquiry team.

Documentary evidence should be provided no later than the **27 June 2021 in electronic form** to:

> Casey van Reyk
> Office of the Chief Operating Officer
> Australian Commission on Safety and Quality in Health Care
> 02 9126 3576
> casey.vanreyk@safetyandquality.gov.au
> PO Box 5480, Sydney NSW 2000

1. Documents relating to relevant Western Australian legislation and Child and Adolescent Health Service (CAHS) and/or PCH regulation, protocols, policies and procedures, best practice guidelines and accepted clinical standards in relation to:

   (a) Emergency Department triage policy and/or process
   (b) Patient monitoring policy and/or process
   (c) Patient and family escalation policy and/or process
   (d) Deteriorating patient policy and/or process
   (e) Patient resuscitation policy and/or process

(f) Clinical supervision of Junior Medical Officers and nursing staff policy and/or process
(g) Emergency Department overcrowding escalation policy and/or process
(h) Ambulance offload policy and/or process
(i) Policy and/or process for calling for an inpatient team referral (paediatrics) for the Emergency Department
(j) Staff replacement policy and/or process
(k) Clinical governance policies regarding risk management, incident management systems and open disclosure, feedback and complaints management. The reporting and review processes for incidents including reporting processes, classification of the severity, investigation and implementation of recommendations for improvement including mortality and morbidity processes and root cause analysis
(l) Open disclosure of clinical error to affected patients and/or next of kin policies and/or process
(m) Clinical handover policy and/or process
(n) Legislation/process/policy for managing concerns about clinician performance
(o) Clinician performance structure/policy/process
(p) Emergency Department models of care for paediatrics including the PCH Sepsis Guidelines
(q) Clinical risk management policy and/or process
(r) Patient, consumer and family engagement policy and/or process including any specific policy and/or process for engaging with multicultural consumers and families
(s) Complaints management policy and/or process
(t) Clinical Incident management policy and/or process
(u) Emergency Department equipment maintenance/repair/replacement policy and/or process and records

2. Documents relating to the clinical care of Aishwarya Aswath including:
   a) PCH paper and/or electronic medical records
   b) Any General Practice or other health care worker notes that may be of relevance prior to Aishwarya attending the Emergency Department (prior 7 days)

3. Documents relating to family engagement including:
   a) A chronology, details and outcomes of interactions with the Aswath family (including with the family representative) to date including from CAHS, PCH, the Western Australia Department of Health (Department of Health) and the RCA review team.

4. Documentation relating to implementation of National Safety and Quality Health Service Standards (NSQHS Standards) including:
   a) Provision of evidence that the NSQHS Standards have been implemented, specifically the Clinical Governance Standard, Partnering with Consumers Standard, Communicating for Safety Standard and Recognising and Responding to Acute Deterioration Standard. The Inquiry team notes that PCH is a relatively new facility and has not undergone accreditation against the second edition of the NSQHS Standards.
   b) The roles and responsibilities of clinicians, management and the executive at PCH, and their escalation of issues to the Child and Adolescent Health Service Board.
   c) The organisational and accountability arrangements within PCH
   d) Documentation regarding the implementation and/or adoption of polices
   e) Patient surveys opinion/feedback/reports in relation to children and their families particularly those of culturally and linguistically diverse (CALD) backgrounds
   f) Staff survey results on culture and workplace
   g) Relevant Medical College accreditation reports. For example from the Australasian College Emergency Medicine

5. Documentation relating to current and previous reviews including:
   a) Any previous reviews conducted in relation to CAHS and/or PCH governance or performance
   b) The RCA Report for Aishwarya Aswath and any relevant action/management plans to address the recommendations completed to date. The Inquiry team will review conduct of the RCA, any issues identified by the RCA, and the recommendations made
   c) Official commentary on the RCA from within the health system
   d) Official communication relating to or measures put in place since the incident (as a result of the incident)
   e) Any relevant RCAs, Reportable Incidents, Clinical Incidents or Near Misses including any assessments of themes related to these incidents including types of incidents, potentially preventable factors, recommendations that have been made and recommendations implemented
   f) Relevant complaints either to the PCH, Department of Health or the WA complaints authority/commission
   g) Relevant referral documents sent to AHPRA, including documentation detailing on what grounds staff were referred in relation to this matter
   h) Relevant Morbidity and Mortality meeting notes and actions
   i) Children's Hospitals Comparative Performance Quarterly Report, Oct - Dec 2020, Women's and Children's Health Network – To be obtained from the Children's Hospital Association (CHA)

6. Documentation relating to PCH and Emergency Department key performance indicators including:
   a) Workload and Staffing – Rosters, skill mix and casual/agency use over 3 years. Any correspondence or reviews relating to workload or staffing levels at PCH. Relevant action or management plans to mitigate any risks.
   a) Activity – Emergency presentations, patient acuity, ambulance presentations over 3 years
   b) Patient Flow Measures – Emergency Access Performance, Triage waiting times, Left Against Medical Advice/ Did not wait, Ambulance offload performance over 3 years
   c) Any audits or reviews undertaken by the PCH Emergency Department
   d) Reports on broader KPIs for example, Hospital Acquired Complications and Sentinel Events

Peer comparisons for this data will be made, where possible.

7. Documentation relating to staff training including:
   a) Continuing education both general and specifically in relation to the identification of deteriorating patients and/or sepsis
   b) Patient or Customer Service training both general and for culturally and linguistically diverse groups

This is an indicative list only. The Inquiry team may request further documentation over the course of their review.

Appendix B: Implementation Oversight Committee Program Status Report: RCA Recommendations

Implementation Oversight Committee

Program Status Report: RCA Recommendations as at 24 September 2021

Program details

Executive sponsor:	▉▉▉▉
Program lead:	▉▉▉▉ ▉▉▉
Reporting period:	11 – 24 September 2021
Report number:	15

Overall program status – commentary

All documentation has been developed and endorsed.

Changes are being socialised with employees in ED.

Monitoring continues through CARE Call reporting and Staff Development Tracker

Triage Audits are occurring each month.

Risks (high and extreme only)

ID	Description	Owner	Baseline rating	With mitigations	Mitigations
3270	Completion of the Risk Identification Form including treatment actions for treatment ED waiting area.	▉▉▉	**Extreme**	**Under review**	Under active review in light of work
New	PMO resourcing to support the RCA program of work to enable implementation of robust solutions within three months.	▉▉▉	High	Medium	• Alternative resource options for PMO have been identified, commencing in September 2021.
New	Perceived data integrity issue identified in iLearn. Reported that employees who are on leave, secondment or have resigned are impacting on the denominator for compliance calculations.	▉▉	Medium	Low	• The human resource information will interface with iLearn and ensure that employees who have resigned, on secondment or on 60 days or more leave are excluded from the counts for reporting.

Overarching program actions completed this reporting period 11 - 24 September 2021

- **Rec 1: Triage Policy** endorsed 25 June 2021. The July Audit Report tabled at IOC 24 September 2021.
- **Rec 2:** Documentation **clinical supervision** endorsed 5 August 2021.
- **Rec 3:** Documentation **capability framework** and **roles and responsibilities** endorsed 6 August 2021. Amendments are required to include the recently approved dedicated resuscitation resources.
- **Rec 4: CARE Call Policy** published on 5 August 2021. Weekly monitoring of CARE Calls continues.
- **Rec 5:** Report on the focus groups regarding PCH Escalation Processes was tabled at IOC on 24 September 2021. Further work required on action owners and timeframes
- **Rec 6:** Continue to support the requests of the External Review Panel.
- **Rec 7: The Action Plan to improve CAHS ability to respond to cultural and linguistic diversity** is underway.
- **Rec 9:** The Contractor continues to manufacture components for ED capital works off site.
  Rec 10: Work instruction for management of unplanned medical leave endorsed on 20 August 2021.
- **Rec 11:** State-wide EDIS Super User Group endorsed **clinical notes functionality** on 4 August 2021. Advice on scope, costing and timeline was expected at IOC 24 September 2021. A letter of support to fast track the implementation of EDIS enhancements was prepared for the Director General of Health to the Chief Executive, Health Support Services (HSS).

Actions due in next reporting period 25 September – 1 October 2021

- **Rec 1:** Triage audit report for August will be tabled at IOC on 1 October 2021. Audit tool includes parental concern and identification of the need for interpreter services. Recommendations from July audit report will be addressed with staff.
- **Rec 2:** Socialisation of nursing roles and responsibilities in ED continues.
- **Rec 3:** Revised ED nursing capability framework including dedicated resuscitation team will be tabled at IOC on 1 October 2021.
- **Rec 4:** The outcome of consultation with CARE Call consumers will be completed by Consumer Engagement and tabled at IOC on 1 October 2021.
- **Rec 5:** The amended report on the focus groups regarding PCH Escalation Processes will be tabled at IOC on 1 October 2021.
- **Rec 6:** Continue to support the requests of the External Review Panel.
- **Rec 7:** The Action Plan to promote cultural and linguistic diversity in the delivery of healthcare will continue to be implemented.
- **Rec 9:** ED capital works are on track for completion in December 2021.
- **Rec 10:** Work Instruction implemented through Medical Workforce for cover of unplanned medical leave.
- **Rec 11:** Information on scope, costing and timeline for EDIS enhancements to be tabled at IOC on 1 October 2021if the information is available for HSS.

![Government of Western Australia - Child and Adolescent Health Service]

Status Key
Red: Significant issues with the project that cannot be resolved solely by the project manager.
Amber: One or more aspects of the project viability (scope, schedule, budget) is at risk.
Green: The project is performing to plan.

Implementation Oversight Committee

Program Status Report: RCA Recommendations as at 24 September 2021

#	RCA Recommendation	Lead	Key deliverables	Initiation	Due Date	Document endorsed	Responsible for socialisation	Monitoring implementation	Initial Evaluation	Evaluation	Impact on children and families	Phase / % complete	Status
1	Develop and implement policy for triage practice including detailed descriptors for the triage, assessment and care for the management of patient's presenting to the ED.	▮	Develop and implement policy for triage practice including detailed descriptors for the triage, assessment and care for the management of patient's presenting to the ED.	17/05/21	28/05/21	25/06/21	Clinical Nurse Manager	25/06/2021 Initial Triage Audit in June	Monthly Audit Schedule July Audit complete	3/12/21	Improved access to care measured through: • timeliness indicators • consumer satisfaction ○ being heard ○ kept informed ○ clear plan	First Phase Complete Phase 2 30%	**On Track** **Ongoing monitoring**
			Develop, implement and resource the role of "Triage Support Nurse": works alongside Triage nurse - taking observations to enable a more thorough assessment and enable early commencement of management.	17/05/21	14/06/21	5/8/21	Clinical Nurse Manager	14/07/21	Observational measure & Consumer consultation planned in October 2021	14/10/21	• Alleviation of parental concern by listening, measuring and documenting a thorough patient assessment. • Measure time point from triage to assessment • Seek parental feedback.	First Phase Complete Phase 2 30%	**On Track** **Ongoing monitoring**
2.	Develop and implement a model for clinical supervision to support all staff in their clinical decision making.	▮	A model of clinical supervision is developed and implemented	31/05/21	30/07/21	5/8/21	Clinical Nurse Manager	6/11/21	6/11/21		Workforce Impact • Employees understand clinical supervision and when to ask for help.	First Phase Complete	**On Track** **Ongoing monitoring**
3.	Review and align nursing clinical roles and responsibilities in ED and align to a capability framework.	▮	Nursing clinical roles and responsibilities are documented	31/05/21		6/8/21	Clinical Nurse Manager				Workforce Impact • Employees understand the roles and responsibilities and ED capability framework in terms of their personal responsibility to maintain skills.	First Phase Complete	**On Track** **Ongoing monitoring**
			A capability framework is developed	18/06/21	30/07/21	5/8/21	Clinical Nurse Specialist	25/02/22	Document to be updated to include dedicated resuscitation resources.			First Phase Complete	**On Track** **Ongoing monitoring**

Government of Western Australia
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Implementation Oversight Committee

Program Status Report: RCA Recommendations as at 24 September 2021

#	RCA Recommendation	Lead	Key deliverables	Initiation	Due Date	Document endorsed	Responsible for socialisation	Monitoring implementation	Initial Evaluation	Evaluation	Impact on children and families	Phase / % complete	Status
4.	Develop and implement a model for a parental escalation process in ED- aligning with the inpatient 'Call and Respond Early' (CARE) Call in consultation with consumer representatives	███	Develop and implement a model for a parental escalation process in ED, aligning with the inpatient 'Call and Respond Early' (CARE) Call with consumer representatives. Welcome to ED brochure will be translated into ten (10) common languages describing CARE Call.	1/01/21	2/07/21	Signage 18/05/21 Policy 5/8/21	ED Heads of Department	1/10/21	Consumer consultation planned in October 2021.	Report to be tabled at IOC by 28 October 2021.	Measure parental confidence to escalate their concerns through • CARE Call • Get a better understanding of consumers understanding of CARE Call	First Phase Complete	**On Track** **Ongoing monitoring**
5.	Ensure contemporaneous education and use of the PARROT (V3) chart is conducted, evaluated and reported.	███	Ensure contemporaneous education and use of the PARROT (V3) chart is conducted, evaluated (including compliance with the process and measure of its effectiveness) and reported.	24/04/21	30/07/21		All Heads of Department	30/08/21	Compliance reported at IOC each meeting. Communications piece planned to elevate PCH Escalation Processes as a priority across CAHS.	Focus group report to be amended and tabled 1 October 2021.	Workforce Impact Employees • Compliance with training • Audit shows nurses know how to use the chart • Nurses interpret and respond to findings appropriately.	**ED Nursing** **PCH All**	**86%** **45%**
6	The organisation conducts an Independent External Review of the emergency department: staffing, patient flow model, clinical supervision and education programme and ensures the monitoring of serious clinical incidents via regular Morbidity & Mortality Meetings, and the findings from this report are considered to inform the terms of reference of this review.	██	TOR published 26 May 2021.	26/05/21	30/8/2021		IOC	Independent External Review Report pending with recommendations. HODs developing scope for the review of the emergency department: staffing, patient flow model, clinical supervision and education programme for IOC.			The review will identify further opportunities to improve governance and the safety and quality of care to children and families.		**In progress**

Government of **Western Australia**
Child and Adolescent Health Service

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Implementation Oversight Committee

Program Status Report: RCA Recommendations as at 24 September 2021

#	RCA Recommendation	Lead	Key deliverables	Initiation	Due Date	Document endorsed	Responsible for socialisation	Monitoring implementation	Initial Evaluation	Evaluation	Impact on children and families	Phase / % complete	Status
7.	The organisation implements an awareness program focusing on CALD populations to ensure patient safety in the ED.	▮▮▮	The organisation implements a review of its ability to respond to cultural and linguistic diversity in the delivery of healthcare across its services including the ED.	31/05/21	19/07/21	20/8/2021	ED HODs	Consumer Engagement	29/10/21	29/10/21	Consumers are aware of the review completed: • Consumers endorsed the action plan • Progress on the action plan is reported to consumers • What would success look like to parents and for children?	First Phase Complete 100%	On track ongoing monitoring
			The outcome of the review should result in improved awareness and practices of clinical staff through education and training in treating patients of different ethnic and cultural backgrounds.	19/07/21	20/8/2021	20/8/2021	ED HODs	Consumer Engagement	29/10/21	25/02/22	Parents will report improved: • cultural security	Phase 2 Action Plan 30%	On track ongoing monitoring
8	Purchase a second blood gas machine for the ED.	▮▮▮	Purchase a second blood gas machine for the ED.	14/05/21	19/05/21	N/A	ED HODs	CAHS Infrastructure	16/6/2021	6/09/21	Timeliness measure • Blood gas analysis is not delayed due to machine failure.	100%	Complete
9	Review and adapt the physical layout of the triage area in ED to facilitate improvements to triage and assessment processes.	▮▮▮	The physical layout of the triage area is reviewed to facilitate improvements to triage and assessment processes.	20/08/21	11/11/21	6/8/21 Contract awarded	CAHS Infrastructure ED HODs	CAHS Infrastructure	4/11/2021 Go-No Go	28/2/2021	Workforce Impact • Employees report more effective workflows with modifications to the workplace. • Parents may observe the workflows in ED work more effectively.	Phase 1 complete Phase 2 20%	On track Ongoing monitoring

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Implementation Oversight Committee

Program Status Report: RCA Recommendations as at 24 September 2021

#	RCA Recommendation	Lead	Key deliverables	Initiation	Due Date	Document endorsed	Responsible for socialisation	Monitoring implementation	Initial Evaluation	Evaluation	Impact on children and families	Phase / % complete	Status
10	Develop and implement a robust system of medical unexpected leave (including sick leave) cover in ED	▉	Develop and implement a robust system of medical unexpected leave (including sick leave) cover in ED.	3/05/21	20/08/21	20/08/21	CAHS Medical Workforce ED HODs	Director Medical Services	1/10/21	15/12/21	Workforce Impact • FTE matches approved workforce allocation. • Employees report satisfactory workforce resources.	Phase 1 complete Phase 2 40%	**On track** **Ongoing monitoring**
11	Develop and implement enhanced functionality to Emergency Department Information System (EDIS) to enable safe handover of clinical information.	▉	Evidence of the enhanced functionality to Emergency Department Information System (EDIS) to enable safe handover of clinical information.	21/05/21	30/07/21	4/08/21	HSS will lead the state-wide EDIS enhancements ED HODs	HSS manage vendor interface, scope (quote pending) and implementation state-wide	Date to be confirmed once enhancements implemented	Timeline line to be determined by HSS	Workforce Impact • Demonstrated clinical notes functionality to improve documentation to enable safe handover of clinical information.	Phase 1 complete Phase 2 10%	**On track** **Ongoing monitoring**

Appendix C: Program Status Report: Response to ANF 10-point Plan Recommendations

Status Key
Red: Significant issues with the project that cannot be resolved solely by the project manager.
Amber: One or more aspects of the project viability (scope, schedule, budget) is at risk.
Green: The project is performing to plan.

Program Status Report: Response to ANF 10 point plan Recommendations as at 24 September 2021

#	Nursing	Lead		Commentary regarding deliverables	Initiation	Due Date	Evaluation due	Impact on children and families	Phase / % complete	Status
1.	Increased FTE to align with NHpPP metrics: • An immediate increase in permanent nursing staff to enable two additional registered nurses rostered for the Emergency Department across all shifts, resulting in an increase of 11.1FTE. • Increased allocation of leave provisions across the nursing establishment, enabling permanent recruitment of an additional 5 FTE, bringing total overall increase to 16.1 FTE.	■■■■	■■■■	• Recruitment targets have been met. • Focus on staff orientation and ED specific training requirements as per ED Nursing Capability Framework. • Ongoing maintenance of FTE	14/04/2021	14/08/2021	14/09/2021 complete	Improved access to care measured through: • timeliness indicators • consumer satisfaction ○ being heard ○ kept informed ○ clear plan	Phase 1 100%	On track Ongoing monitoring
2.	An additional nurse allocated to monitor patients in the Emergency Department waiting areas	■■■■	■■■■	• Roles and responsibilities of the waiting room nurse defined.	14/04/2021	30/07/2021	24/09/2021 complete	• Alleviation of parental concern by listening, measuring and documenting a thorough patient assessment. • Measure time point from triage to assessment • Seek parental feedback.	Phase 1 100%	On track ongoing monitoring
	An additional nurse allocated, supporting areas with higher levels of activity across the Emergency Department	■■■■	■■■■	• Roles and responsibilities of the support nurse defined	14/04/2021	30/07/2021	24/09/2021 complete		Phase 1 100%	On track ongoing monitoring
	Triage Support Nurse (TSN) role to be implemented.	■■■■	■■■■	• Roles and responsibilities of the TSN defined.	14/04/2021	30/07/2021	24/09/2021 complete		Phase 1 100%	On track ongoing monitoring
3.	A *designated* ED Resuscitation Team on every shift, supported by senior medical and nursing staff from within the hospital attending every resuscitation in the Emergency Department.	■■■■	■■■■	• Roles and responsibilities of the resuscitation nurses designated each shift. • Has been expanded to allow – dedicated – see next element	14/04/2021	28/05/2021	30/08/2021 complete	Improved access to care for Category 1 patients measured through: • timeliness indicators • consumer satisfaction.	Phase 1 100%	On track ongoing monitoring
	Update: Additional nursing resources have been approved to provide a *dedicated* ED Resuscitation Team on every shift, attending every resuscitation in the Emergency Department. (yet to commence)	■■■■	■■■■	• BN endorsed supporting increase in nursing resources for a ED Resuscitation Team • Allow 12 weeks for recruitment	20/08/2021	20/12/2021	20/01/2022		Phase 2 10%	On track Recruitment Initiated
4.	The establishment of an Emergency Department Consultative Working Group, co-chaired by a member of the Emergency Department nursing team.	■■■■	■■■■	• Meeting fortnightly – 5 meetings to date with minutes and actions recorded.	14/04/2021	2/07/2021	4/09/2021 meetings effective	Workforce Impact • Employees consulted on changes being implemented in the department • Voice of staff heard on a fortnightly basis.	100%	On track Ongoing monitoring

Program Status Report: Response to ANF 10 point plan Recommendations as at 24 September 2021

#	Nursing Plan	Lead	Project Manager	• Key deliverables	Initiation	Due Date	Evaluation due	Impact on children and families	Phase / % complete	Status
5.	An increase to the allocation of Staff Development Nurses (SDN) in the Emergency, effectively doubling the allocation.	▮	▮	• Completed. • Recruitment process completed.	14/04/2021	28/05/2021	30/06/2021 complete	Workforce Impact • Increased capability for education, training and supervision on new and existing employees. • Evidence through the Staff Education Tracker	100%	On track Ongoing monitoring
6.	Phased commissioning of 10 HDU beds by 28 February 2022 Stage 1 - 2 beds 11 October 2021 Stage2 - 4- 5 beds 19 December 20201 Stage 3 – 8 beds by 31 January 2022 Stage 4 - 10 beds by 28 February 2022 This deliverable is dependent on the ability to recruit a suitably skilled workforce in the timeframe.	▮	▮	• HDU is currently on track for October 11 towards Stage 1 initiation of two (2) additional beds. • Stage 2 will follow with 4 - 5 beds being available by December 19, 2021. • CNS and Staff Development Nurse for HDU recruited.	14/04/2021	28/02/2022	30/04/2022	Improved access to care for consumers measured through: • timeliness indicators for access to care on the ward • timeliness indicators for access to elective surgery requiring HDU/ICU access. • consumer satisfaction with plan of care.	Phase 1 15%	At Risk Workforce constraints
7.	The PCH Winter and Surge Bed Management Plan has already been put in place to meet current demand and is available to staff.	▮	▮	• The bed management and patient flow policy has been revised to include over census activation principles.	20/8/2021	9/11/2021	30/11/2021		Phase 1 100%	On track Ongoing monitoring
8.	Introduction of rapid nurse recruitment and additional support for on-boarding across PCH, along with enhanced graduate nursing capacity to optimise permanent recruitment to the increased FTE.	▮	▮	• Nursing recruitment continues as BAU process, mapped to the approved workforce FTE requirements.	20/04/2021	30/07/2021	7/09/2021 Ongoing BAU	Workforce Impact • Increased workforce capability to manage BAU or surges in activity consistent with NHpPD or NHpPP metrics. • Reduced incidence of staff overtime or double shifts.	Phase 1 100% Phase 2 Increase graduate nurses	On track Ongoing monitoring
9.1	The establishment of a Medical Short Stay Unit to provide treatment for general paediatric patients with a Length of Stay <72hrs to support timely admission, improved outcomes, and improved emergency access.	▮	▮	• Keeping the MSSU model has proved challenging after the first fortnight, due to demand. • A Fellow dedicated to the model is continuing to provide rapid reviews.	14/04/2021	Suspended 3/05/2021		Key enabler for #7		
9.2	Opening of 10 additional paediatric ward beds in a phased approach aligned to nursing recruitment	▮	▮	• As at 2 July 2021, all 10 additional hospital inpatient beds are open and staffed.	14/04/2021	5/07/2021	13/08/2021 complete	Key enabler for #7	Phase 1 100%	On track Ongoing monitoring

Status Key
Red: Significant issues with the project that cannot be resolved solely by the project manager.
Amber: One or more aspects of the project viability (scope, schedule, budget) is at risk.
Green: The project is performing to plan.

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Child and Adolescent Health Service

Program Status Report: Response to ANF 10 point plan Recommendations as at 24 September 2021

#	Nursing Plan	Lead	Project Manager	Key deliverables	Initiation	Due Date	Evaluation due	Impact on children and families	Phase / % complete	Status
9.3	The expansion of the Surgical Short Stay (Ward 3C) to support an increase in theatre sessions and emergency theatre access.	▇	▇	**Weekdays** • Interviews are underway to resource an additional 4 – 6 beds up to 21 beds, with a commencement date 4 – 6 weeks after interview have been completed. • Additional graduate placements have been accepted to increase nursing establishment **Sunday** • 3C will commence accepting patients on Sunday 12 September. • Patients will be admitted from 7am onwards as direct admits for surgery (i.e. seen in ED Saturday and sent home to return Sunday morning for surgery) as well as patients admitted during the day from ED for surgery. • 8-10 beds opened with 3 nurses, including a coordinator • Data review suggests 12 patients across the day if there are short day cases in the morning that come in and are discharged by midday. • The plan is to pilot activity for eight weeks and review utilisation.	14/04/2021	12/09/2022	14/10/2021	Key enabler for #7	Phase 1 100% Phase 2 underway	**On track** **Ongoing monitoring**
10	CAHS has a Service Level Agreement (SLA) with NMHS to provide security staff.	▇	▇	• Business as usual (BAU) managed by Service Level Agreement (SLA) with North Metropolitan Health Service.	BAU	NA	As per SLA	Workforce Impact • Employees report security services are well prepared for paediatric environment and respond to incidents appropriately.	BAU	**On track** **Ongoing monitoring**

3

Appendix D: PCH twenty beds

Perth Children's Hospital (PCH) – Twenty (20) Beds

KEY MESSAGES

- **PCH opened an additional 10 multiday inpatient beds in June 2021.**
- **PCH also plans to increase bed capacity by 10 beds in the Paediatric High Dependency Unit (HDU) via a staged approach.**
- **PCH has established a Patient Access and Flow Improvement Program under the oversight of the A/Executive Director Nursing Services to monitor a comprehensive program of ongoing and future strategies in response to ongoing challenges.**
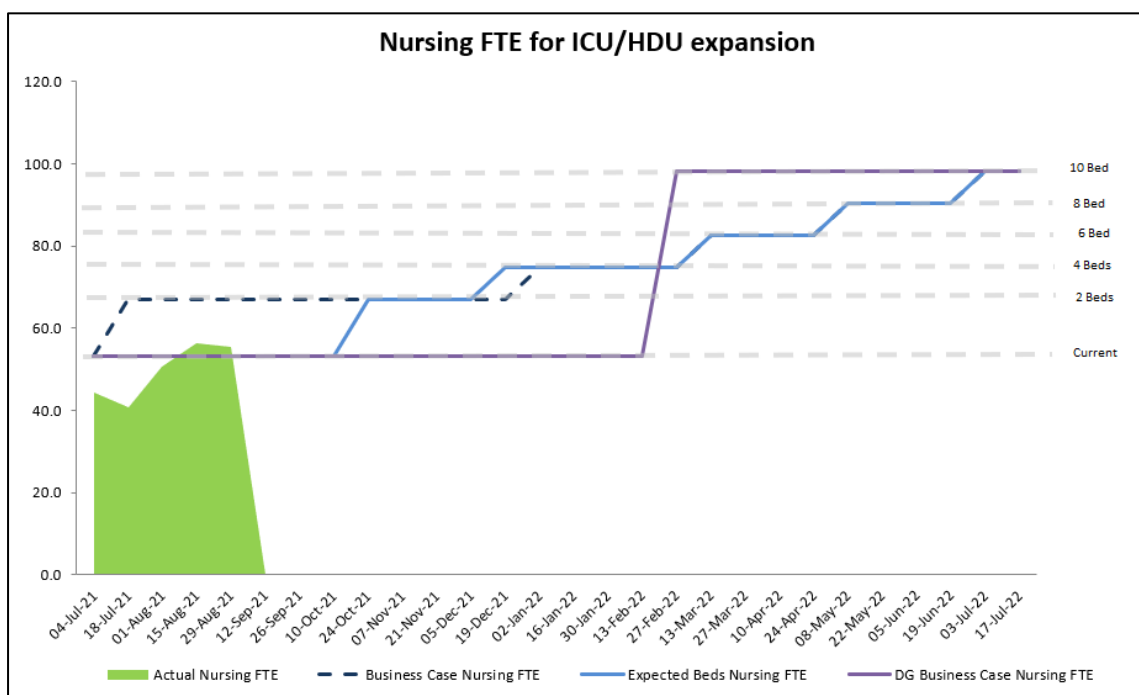
CURRENT SITUATION

- To address activity and demand, PCH opened an additional 10 multiday inpatient beds in June 2021.
- In the period from May 2021 – August 2021, Emergency Department (ED) presentations were up by 33.7% compared to the same period in 2019/2020:
  - Presentations relating to mental health and adolescent medicine remained high during March to June 2021, comprising 4.7% and 4.2% of all admissions at PCH.
  - For March to June 2021, admissions for adolescent medicine have increased by 65% when compared to the same period in 2019/20; and by 85% when compared to the same period in 2018/19.
- Increases have coincided with sustained high bed occupancy during May – August 2021, with average daily occupancy up 3.5% on the same period in 2019/20; and 1.9% on the same period in 2018/19.
- Review of the nursing establishment for PCH inpatient areas was undertaken identifying an additional 43.85 FTE required to staff additional beds.
- A successful nursing rapid recruitment program was undertaken with over 138 nurses new to Child and Adolescent Health Service (CAHS) appointed to date.
- Patient Access and Flow Improvement Program (as mentioned above) has been established to monitor a comprehensive program of ongoing and future strategies in response to ongoing challenges including ensuring adequate nursing workforce to meet service need.
- PCH also plans to increase bed capacity by 10 beds in the Paediatric High Dependency Unit (HDU) via a staged approach.
- Given the needs of the patient cohort to be managed in this area, commissioning of the 10 HDU beds is principally dependent upon the ability to recruit appropriately skilled medical, allied health and nursing staff, with availability of nursing staff being the major limiting factor.
- Barriers to recruitment of nursing staff include: a fixed pool of suitably skilled paediatric critical care nurses in WA and limitations on interstate and overseas travel associated with the COVID pandemic.
- Whilst CAHS remains committed to achieving the previously communicated timeline, it is unlikely that this will be able to be achieved.
- Figure 1 below outlines the likely timeframe that the staged increase in nursing staff required to commission all 10 HDU beds. Please note the revised FTE recruitment line is based on recruitment success and takes into account staff attrition.
- Noting that recruitment needs to be brought on in a staged way to allow for safe management of patients by competently trained staff who need to be supported by senior staff and by swamping preceptors with novice nurses would result in clinical risk.
- PCH is progressing towards Stage 1 implementation of two HDU beds on 11 October 2021, without any changes to infrastructure and supportive allied health and medical staffing.
- The PCH Surgical Team is in active collaboration with PCH Allied Health, to ensure adequate recruitment of allied health staff to meet the requirements for increasing HDU bed capacity by four beds by 19 December 2021.
- Additional medical staff were not available in the immediate and short term, however recruitment for 2022 is currently underway. Assuming all staff accept their offers of appointment, there will be sufficient medical staff to support the maximum increase of HDU beds by 31 January 2022.

- A national recruitment drive for intensive care nurses has closed, and 5 – 6 FTE of nursing staff have been identified to be suitable; however, lead times will be subject to interstate relocation and facilitation of commencement dates.
- Additionally, the Office of the Chief Nursing and Midwifery Officer has announced an international recruitment program, inclusive of critical care.
- The HDUs additional Furniture, Fixtures and Equipment (FF&E) has a lead time of 12 weeks for delivery and the order has been placed. The first delivery of FF&E has arrived at PCH on 20 September 2021.
- The recruitment steps for HDU nursing staff are as follows:
  - 3 FTE of senior nursing staff commenced 13 September 2021.
  - An expression of interest for experienced critical care trained nursing staff to transfer from within CAHS to the HDU is currently being advertised, with a number of staff already expressing their interest.
  - Advertisement for an additional Staff Development Nurse for the HDU program is now active.
  - Additional overtime of Staff Development Nurses has been authorised to enable HDU program development
  - One-week HDU upskill program will run on 18 October 2021 with an expression of interest for HDU staff in progress; 10 FTE can be accommodated in this program, subject to application.
  - The third transition to critical care program will take place on 22 November 2021, applicants are being assessed, 5-6 FTE are likely to be inducted into this program.
  - December 2021 will focus on recruitment of a Clinical Nurse Specialist to support new novice staff as FTE expands, in addition to advertising for a Clinical Nurse to ensure adequate skill mix within the critical care environment.
  - The adult to paediatric secondment program will commence 17 January 2022, 6 FTE to be targeted; however, this will be subject to applications for secondment received from adult services.
  - The novice cadet program will commence on 7 February 2022, with 7 FTE targeted to enter practice.
  - Ongoing additional recruitment will continue during this time to maximise rapid escalation of expected bed base. This needs to occur in a staged approach to ensure safe practice environment in delivery of HDU care.

BACKGROUND

- PCH reconfigured ward specialties and undertook a review of nursing establishment in 2020 in response to the COVID19 pandemic and as an overall review of services across clinical areas.

Figure 1: Nursing FTE Targets for HDU per pay period HDU program life

CURRENT AS: 21 September 2021
CONTACT:
Endorsed:

Appendix E: Resourcing Commitments FY21/22

Source: Child and Adolescent Health Service - October 2021

BRIEFING NOTE

ISSUE

- Updated summary of CAHS resourcing commitments for 2021-22.

BACKGROUND

- To best understand the expenditure, it is important to look at staff growth since January 2021.
- As at 30 September 2021, some 80 resourcing commitments and requests have been included within the current CAHS forecast. All commitments have been phased in across the year taking account of timeframes for recruitment, service expansion and availability of resources.

FY 2020-21

- From January to June 2021, there was an increase of 189 FTE (excluding 214 FTE increase for COVID-19) across the directorates as detailed below:

	Jan-21	Jun-21	Increase
Medical Services	151	170	19
HIAS (records & admissions)	178	192	14
Neonates	425	432	7
Medicine	638	663	25
Surgical	566	609	43
CACH	820	843	23
CAMHS	371	384	13
Coordinator of Nursing	48	57	9
Staff Health	2	2	1
Allied Health	174	196	22
COVID	11	25	14
COVID Vaccination (includes Nursing and admin)	-	200	200
Corporate growth	359	372	13
Total CAHS FTE	**3,742**	**4,145**	**403**

- FTE growth across professional categories:

	Sum of FTE
Admin *(includes 100 related to COVID)*	141
Medical	23
Medical Support	48
Nursing	192
Grand Total	**403**

CURRENT SITUATION

FY 2021-22

- In 2021-22 an additional series of investments have been made estimated at $68.1M.
- The following table details the breakdown showing the forecast increased costs for 278 FTE to be recruited in 2021-22, to support the opening of an additional 22 beds and other activity pressures across Perth Children's Hospital, together with additional investments into CAHS community services. Both FTE and expenditure are for part year.

	Sum of $M	Sum of FTE	Sum of Beds
Allied Health	4.7	12	0
Community Health	1.6		0
Emergency Department	8.5	40	0
Medical Services	1.6	5	0
Medicine	15.4	59	0
Neonates	7.9	14	0
Nursing Services	1.6	10	10
Operations	2.1	25	0
People, Capability and Culture	3.2	10	0
Procurement, Infrastructure, Contract Management and ICT	1.6	7	0
Safety, Quality and Innovation	1.8	7	0
Surgical	18.1	90	12
Total	**$68.1**	**278**	**22**
COVID	7.3	27	0
COVID Vaccination Nursing	34.9	241	0
Total COVID	**$42.2**	**268**	**0**

   Neonates business case remains under consideration

- Included in the $68.1M increase, is $26.1M of items that do not have additional FTE impact in 2021-22, including expected funding for additional activity delivered in 2020-21 ($18M), the CDS waitlist funding ($1.6M, FTE increase in FY20/21) and other items such as ICT systems, services, maintenance and supplies ($6.5M).

- The balance of $42M is increased investment in the additional 278 FTE across the following professional categories:

	Sum of FTE
Admin	64
Hotel Services	3
Medical	47
Medical Support	12
Nursing	152
Grand Total	**278**

- Within the Emergency Department figures above, the following costs have been included:
  - Nursing - May 2021 additional 17.38 FTE
  - Nursing - August 2021 a further additional 25 FTE, forecasted across the financial year with all resources in position by 31 October 2021.

  Note that the combined total of 42.38 FTE is a full-year impact, which translates into 40 FTE when phased in 2021-22.

- Within the Medicine directorate, the following FTE have been included:
  - JMO's Emergency Department - June 2021 additional 12 FTE with all resources in position for the full financial year.

- In addition to the 278 FTE, an additional 11.6 FTE of ED Consultants have been approved but not included in the forecast, due to timing. This FTE will be added to CAHS forecast in October, phased across the financial year with consideration for recruitment schedules and estimated applicant availability.

- Post the drafting of the previous BN, on 1 October 2021 CAHS were advised by Department of Health of an increase in funding of $54M for 2021-22, as part of the state budget process.

- Included in the budget allocation update is an increase in MHC funding of $4.6M for CAMHS (35 FTE) and funding for specific items of $1.5M as detailed below:

Additionally funded items	Sum of $000	Sum of FTE
CAMHS	$ 4,583	35
ED Workforce Package - Graduate Nurse - Transition to Practice Program	$ 117	
Better Beginning's Election Commitment - Multicultural Community Services	$ 163	
Children's Hospice	$ 1,200	
Curtin Interns	$ 22	
Total	**$ 6,085**	**35**

- Attachment 1 (Forecast 2021-22) provides the full breakdown of all relevant resourcing commitments across CAHS.

WA State Budget Papers

- Within the recently released state budgets the following comments are specific to CAHS:

Bolstering youth mental health support

99 additional staff positions for Child and Adolescent Mental Health Service - 35 positions funded through the Mental Health Commission and a further 64 positions to be provided by the Child and Adolescent Health Service

Projects being progressed:

$3.2 million towards the planning and design of a dedicated Children's Hospice

Emergency Department Support Package

$4.8 million towards additional staff for patient monitoring in waiting areas at Perth Children's Hospital ED

Our Ref: CD/21/456167
Enquiries to: cahs.board@health.wa.gov.au

Dr D J Russell-Weisz,
Director General
WA Department of Health
189 Royal Street
EAST PERTH, WA 6004

Via email: David.Russell-Weisz@health.wa.gov.au

Dear Dr Russell-Weisz,

RESPONSE TO THE REPORT OF THE INDEPENDENT INQUIRY INTO PERTH CHILDREN'S HOSPITAL.

The Independent Inquiry into Perth Children's Hospital (PCH) has provided an opportunity to examine, from a holistic view, the factors inside the hospital which may have contributed to the death of Aishwarya Aswath in April this year.

The Report of the Independent Inquiry into PCH (the Report) has provided a longer and deeper perspective of events, practice and culture that culminated in a set of circumstances, whereby when Aishwarya presented to the PCH on that day with a time critical sepsis, her rapid deterioration did not receive an optimal response.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) refers to deterioration from sepsis being rapid and unpredictable, particularly in children, and it is undertaking a program of work to improve early recognition, treatment and outcomes.

The Report emphasises, and reminds us, that our approach to clinical governance, risk, adverse incidents and the culture of consumer service is crucial in determining the experience and outcome of every patient.

The Child and Adolescent Health Service (CAHS) acknowledge and accept the Report provided by the ACSQHC following its inquiry and all its recommendations.

Many of the recommendations within the Report have already been enacted by CAHS in a diligent commitment to improve clinical governance. We accept and commit to

implementing all the recommendations and note that work has already begun. We acknowledge that improvement must be embedded and tested over time.

As we strive to achieve the highest levels of safety and quality, our focus on the patient must be a permanent driver for everything we do.

We will honour the legacy of Aishwarya by working to deliver an improved healthcare system for all children in Western Australia (WA).

OUR RESPONSE TO THE FAMILY

We acknowledge the devastation experienced by the Aswath family as a result of the loss of Aishwarya. We can only imagine what it is like to wake each day without their daughter, sister and loved one.

In the wake of Aishwarya's death, as it is with the loss of any child in our health service, we sincerely feel that we would do all that we could to have changed the moments in time, in our care, that might lead to that outcome. We must ensure that every moment provides the safest environment for our children and the very best of care. The Board, Executive and staff of CAHS make this commitment.

We have heard the Aswath family's distress, concerns and specific complaints. We hear their anguish, anger and disbelief that skilled clinicians could have misinterpreted Aishwarya's presenting signs and symptoms, and that the family's concerns were not accepted and escalated. We acknowledge that they experienced a lack of urgency, a lack of communication and a lack of compassion.

As a result of Aishwarya's death, experience with PCH, and the subsequent events related to the internal investigation instigated by CAHS immediately after the tragic incident (the Root Cause Analysis), the Aswath family has expressed anger and hurt at a system that was there to look after their daughter. This encompasses all aspects of the care provided to Aishwarya and the hospital's response following her death.

Understandably, this has resulted in a breakdown of trust which has prevented PCH providing support, and at the same time, increased the suffering and grief experienced by the family.

The indescribably devastating experience of witnessing rapid deterioration, attempted resuscitation and death of their child; and the hospital's handling of events after the death are recognised by CAHS as areas for reflection, learnings and immediate change.

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Aishwarya was a brave little girl, and although she was terribly unwell with a fatal sepsis, she tried to respond to nurses when they spoke to her, she lifted her head respectfully, and engaged. Her parents were also respectful; reassured that they were in the best place for their sick child, reassured by having been attended to by a nurse, and briefly by a doctor, and complying with the posters in our ED that requested that parents be patient and polite, they waited and cared for their daughter until assistance arrived.

We as a health care community recognise that families may have a culturally determined propensity not to be assertive and apply pressure to staff, despite their fears and sense of abandonment. Improved awareness of cultural differences needs to be embedded into the care we provide and we will commit to ensure that every family is seen and heard. We must ensure that there are no gaps in our sensitivity.

The Report has identified specific opportunities for CAHS to learn as an organisation and to engage with the family, addressing the concerns they have raised. These include:

1. re-engagement with the family with a frank and open conversation regarding the events that occurred that night, and directly addressing the concerns that they have raised;
2. engagement with the family in honouring Aishwarya's memory by development of commemorative projects beyond Aishwarya's CARE Call;
3. supporting a clinician-led conversation with the family regarding the PARROT chart to better develop and integrate the "parental concern" component of the assessment; and
4. utilising the family's expertise in developing policies, procedures and training regarding bereavement services, including incorporation of religious and spiritual traditions.

We acknowledge that there were gaps in the Executive notification, communication, and support mobilised in the wake of Aishwarya's death. To have a family feel so unsupported while they were in our care is unacceptable. The family feel that they have not had complete open disclosure. There has not been an opportunity for PCH to engage with the family in healing and the Report has reinforced that in every case where there is a child in our care, our relationship and connection to the family is crucial to their treatment and recovery, healing and wellbeing.

CONSUMER ENGAGEMENT

We acknowledge that Aishwarya's parents were not heard. Parents know their children better than anyone and parental concern is vital in the assessment of a child. The Report reinforces the criticality of meaningful engagement with consumers and their families, so as to ensure that the powerlessness felt by the Aswath family is not experienced by others.

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We must be inclusive and responsive. The Report reinforces the inclusion of consumers and their families in clinical decision making for the greater good of the child, as well as engagement in CAHS clinical service planning and development to ensure consumer-centred care. We will bring the voices of the Youth Advisory Committee (YAC) and the Consumer Advisory Committee (CAC) live to the Board table.

The Report has recognised CAHS efforts in developing services sensitive to Aboriginal and Torres Strait Islander children and families. CAHS now has an added focus on the strengthening of data collection, management and reporting, related to those from Culturally and Linguistically Diverse (CaLD) backgrounds. The embedding of cultural competency training across the organisation, and being able to identify children and families with specific needs, will better inform clinical decision making. We must be more than "not discriminating". This requires a sensitive ability to respond to the uniqueness of each individual and their circumstances and be open to the people in our care.

SAFETY & QUALITY

The Report recognised the robustness of the RCA process undertaken and acknowledged PCH's activity related to the implementation of the recommendations. There is an attachment to this letter that describes the actions implemented at PCH resulting from the recommendations of the RCA and further CAHS program of works under the Board's direction.

The Report outlined that a Safety and Quality Framework for reporting and responding to clinical review processes be developed incorporating a communication framework of RCA/investigation outcomes, evaluation, reporting and monitoring of recommendations.

This review and implementation of new processes in safety and quality have already commenced. It is implicit in health care that we scrutinise every adverse event that may occur, fully investigate, find learnings and make recommendations. We must then implement recommendations in a timely manner and complete the process by auditing to ensure that they are embedded in practice. It is only through this diligence and focus on reducing preventable harm of patients that we can restore confidence and improve patient outcomes.

This also applies to morbidity and mortality outcomes that must also be connected to the overall safety and quality process. There must be improvement in the ability for clinicians to call out clinical risk, and have processes in place for action to mitigate, minimise or eliminate these risks.

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Further, patient complaints and concerns need not just a personal and satisfactory response by CAHS, but also a high level of analysis and scrutiny, as they provide insight into our family and patient experiences. Complaints need to be considered within a Severity Assessment Criteria (SAC) framework to ensure that they are given the strength of consideration required and lessons learnt, application of change and embedding of improvement must occur along with sensitive acknowledgement and response.

OUR RESPONSE TO STAFF

The Report recognised that PCH has consistently been a leader in paediatric clinical care as shown through National and International benchmarking data. However, increasing clinical activity and workforce challenges have had an impact.

We acknowledge ongoing concerns about staffing shortages, the pressure of increased presentations and the uniqueness of PCH as a tertiary/quaternary provider, with available bed numbers and resources, all being ongoing underpinning risks to our ability to meet our patient's needs to the highest quality of clinical outcome and experience.

However, it is our role and responsibility to continuously rise to this challenge. This requires diligent, effective utilisation of our resources and funding, highly trained and continuously developed clinical staff; effective, maintained and up to date equipment; and clear advocacy for more resources, staff and funding. We need to anticipate and respond to changes in trends and rapidly growing demand to meet the health needs in our child and adolescent community. This is particularly significant in the area of mental health. It also requires CAHS and all of its dedicated employees to reinforce the culture that is driven by putting the patient first. Staff must be able to escalate and be heard in their call for resources to ensure patient safety.

We have already commenced work on removing physical barriers within the PCH ED and have appointed additional triage and waiting room staff to maximise consumer and family engagement with clinicians and elevate responsive care. Recognising the nursing workforce shortage, our staff have embraced new nursing additions into our teams who undertake a three week training, supervision and mentoring period in order to upskill in paediatrics. They are vital in our ability to add trained eyes, ears, hands, hearts and minds to our frontline nursing workforce.

The CAHS Board is seeking the integration of paediatric clinical care across the WA health system to ensure comprehensive and timely care closer to home. This requires funding allocations/redistributions, robust referral systems, maximisation of secondary inpatient services, integrated inter hospital patient transfer, comprehensive outpatient services and engagement with community service providers. The improvement of

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information transfer and tracking of the patient is essential in this. We will work closely with the WA Department of Health and State Government to achieve this.

The Report found that workforce challenges secondary to COVID-19, clinician shortages, utilisation of the existing redundancy in workforce and abnormal activity patterns had affected PCH and the ED.

We acknowledge as per the Report that increasing staff permanency, training and supervision, Junior Medical Officer (JMO) support and using clinical specialists in their areas of expertise will improve safety and morale.

We have experienced the impact that events following the death of Aishwarya have had on the relationship between management and clinicians. We understand that to establish strong trust between PCH clinicians and management, robust engagement of clinicians in both system decision making and development of clinical governance systems is required.

CULTURE

The organisational culture was considered as a backdrop to the tragic death of Aishwarya. The CAHS Board is concerned that the Inquiry team observed that the family experienced defensiveness from PCH. The CAHS Board is determined to overcome any defensiveness in the organisation which we believe is a barrier to true reflection, humility, insight and responsive improvement.

There has been longstanding trauma within the organisation resulting from the long transition to the new hospital site, previous reviews into workplace relations, COVID-19 and the increasing workforce challenges. There is significant trauma from the sad loss of Kate Savage and Aishwarya Aswath, and all and any child in our care.

In order to move forward, PCH also needs to heal. This requires a unification and respect for each other in our clinical workforce, and at all levels and all specialties across the organisation to work cohesively developing and delivering services focussed on the children and families.

It should also be said that every recommendation that relates to PCH, will be applied to every service provided by CAHS, which includes community health, mental health and neonatal services operated out of King Edward Memorial Hospital (KEMH).

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CONCLUSION

This is not a conclusion but an ever-diligent journey of continuous improvement in health care. We must aim for zero preventable harm to those in our care and that requires the implementation of all the recommendations in the Report and our ongoing commitment to the children, young people, families and the community of WA.

We must measure and benchmark ourselves. We must seek excellence and not be blinded by a conviction that we cannot improve. We must learn from centres of excellence and listen to our own people when they are calling out for safety and quality. We must engage with the young people in our care who can open our eyes to what they see and experience, and what they understand from other patients and families. We must replace defensiveness with humility.

Our passion for delivering the best care to children, adolescents and young people in our health service must be supported by systems and tools that enable us.

We must honour the memory of Aishwayra Aswath, and all who have experienced an adverse outcome in our care, with a commitment to improve and embed a culture of learning and clinical excellence.

We must restore confidence and trust in CAHS by demonstrating the commitment and compassion of our staff for children and young people.

Yours sincerely

Dr Rosanna Capolingua
Board Chair
Child and Adolescent Health Service

8 November 2021

ATTACHMENT:
1. CAHS Program and Plans of Works

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ATTACHMENT 1: CAHS PROGRAM AND PLANS OF WORK

CAHS has commenced a program of work to address recommendations of the RCA and Australian Nursing Federation (ANF) 10-point plan with actions undertaken so far listed below.

GOVERNANCE

1. Completion of the Independent Inquiry into Perth Children Hospital.
2. Development of the Implementation Oversight Committee to co-ordinate, monitor and report on CAHS activities related to the recommendations from the RCA.
3. Development of the Implementation Oversight Committee to co-ordinate, monitor and report on CAHS activities related the ANF 10-point plan.

SAFETY & QUALITY

1. Submission of correspondence to WA Health regarding the re-establishment of the Statewide Safety & Quality committee, with CAHS representation by the Board Safety &Quality Committee Chair.
2. Presentation of all SAC 1, 2 &3 incidents for consideration of the Board on a weekly basis.

CONSUMER ENGAGEMENT

1. Implementation of the Aishwarya's CARE Call system across PCH to enable parental escalation of concerns regarding their child.
2. Integration of the Diverse WA Cultural Competency training program into the CAHS learning management system for implementation within the Mandatory Training framework.
3. Initiation of procurement of Cultural Competency training program from the Centre of Culture, Ethnicity and Health.
4. Development of language services material to support enhanced access by staff to interpreters whilst working with CaLD families.
5. Development of a CaLD dataset for integration within the current RCA process.
6. Development and implementation of the CAHS Multicultural Plan and CaLD Patient Safety Awareness Program.
7. Review of Consumer Feedback related to ED activity for the previous three (3) months has been completed including review of the MySay Healthcare Survey - Emergency Medicine and CaLD patients, Net Promoter Score, Care Opinion and consumer complaints and compliments and development of an action plan to address identified issues.

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8. Formalisation of the Consumer Engagement Moment within the CAHS Board Meetings agendas, including tabling of current complaints and compliments for discussion includingconsumer journey and CAHS response.
9. Engagement of Consumer Advisory Committee (CAC) and Youth Advisory Committee (YAC) Chair at CAHS Board meetings including tabling of Committee meeting minutes forconsideration by Board Members.

CLINICAL SERVICE

1. A new Bed Management Model to increase bed capacity across the services.
2. Commissioning of the 10 bed High Dependency Unit (HDU) to enable targeted clinical care for children with higher acuity.
3. Development of a Medical Short Stay Unit (MSSU) model to provide targeted clinical care, support timely admission and improved access to ED.
4. Opening of ten (10) additional paediatric beds across PCH to increase capacity and improve patient flow.
5. Expansion of the Surgical Short Stay Unit (SSSU) to support increased theatre sessions and emergency theatre access.
6. Completion of the enhanced functionality brief for the Emergency Department Information System (EDIS) to enable safe handover of clinical information.
7. Representation at the WA Health Electronic Medical Record (EMR) Working Group.
8. Identification of CAHS as an early adopter for Stage 1 Core deliverables of the WA Health Digital Health program.
9. Appointment of a CAHS Bereavement Coordinator

EMERGENCY DEPARTMENT

1. Implementing a Sepsis pathway and guidelines
2. Provisioned an additional blood gas machine
3. Modification of physical barriers within the PCH ED triage to enable improved access for children and families presenting to PCH ED.
4. Development of a program of works to improve physical access and visibility for staff,children and families within the waiting area of PCH ED.
5. Changes to signage within PCH ED regarding ability to access clinical support by families whilst supporting the zero tolerance to violence message.
6. Employment of permanent nursing staff to enable two additional nurses across all shifts ensuring waiting room nurses to monitor children in case of deterioration at all times.

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7. Increased leave cover provision.
8. Employment of dedicated triage support nurses to support accurate triage of children presenting at ED.
9. Employment of additional Staff Development Nurses (SDN) within the ED to support workforce development and training.
10. Actively recruiting for a dedicated ED Resuscitation Team on every shift.
11. Development and implementation of the policy outlining the triage, assessment and care for the management of children presenting to ED.
12. Implementation of contemporaneous education for all clinical staff in the utilisation of the PARROT (V3) chart.
13. Actively recruiting to expand Emergency Short Stay Unit to utilise all beds

NURSING WORKFORCE

1. Introduction of an accelerated nurse recruitment process and additional support for on-boarding across PCH.
2. Increase by an additional 106 full time equivalent nursing staff across PCH between April and September 2021 under an accelerated recruitment process.
3. Increase by an additional 21 full time equivalent nursing staff within PCH ED between April and September 2021.
4. Reprioritisation of essential skills as part of the nursing recruitment process to expand the recruitment pool to those without specific paediatric nursing experience.
5. Development of the paediatric nursing upskilling program to support the employment of nurses without specific paediatric clinical skills.
6. Enhanced graduate nursing program to increase the employment of additional nursinggraduates across CAHS.
7. Development of the Nursing capability framework to align nursing roles and responsibilities within the PCH ED.
8. Development and implementation of a clinical supervision model to support clinical decision making.
9. Development of the Nursing Advisory Group to support professional communication across the nursing leadership and escalation of identified issues to CAHS Executive.
10. Actively recruiting a mental health clinical nurse specialist to ensure 24/7 cover in PCH ED.

MEDICAL WORKFORCE

1. Increase by an additional 17 full time equivalent Medical Staff across PCH ED between April and September 2021.
2. Implementation of additional medical resources and on call provisions within the PCH ED.
3. Improved leave cover as a consequence of additional clinical resources.
4. Development of the Medical Advisory Committee to support collegiate examination of clinical practice.

RISK MANAGEMENT

1. Review of the current internal audit program with the addition of ten audits with focus to examine clinical governance, quality and risk settings

ORGANISATIONAL CULTURE

1. Ongoing support for the Shape our Future Program including the planning for the repeat of the Barratt's Culture Survey.
2. Development of the Shape Our Future Strategy Version 2 for implementation across the organisation.
3. Development of the CAHS Mental Health Cultural Action Plan.
4. Development of an organisation action plan secondary to the receipt of the 2021 YourVoice in Health Survey results and communication to all staff of the results.

PEOPLE, CAPABILITY AND CULTURE

1. Implementation of an organisational wide conversion to permanency program for all staff.
2. Establishment of a Talent Acquisition and Recruitment Team to support the recruitment and retention of CAHS staff.
3. Employment of on-site psychological staff to address psychological hazards identified within the workplace.
4. Development and implementation of the CAHS Health and Wellbeing strategy for staff.

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