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

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Dr D J Russell-Weisz,
Director General
WA Department of Health
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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

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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.

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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 recruitmentand retention of CAHS staff.
3. Employment of on-site psychological staff to address psychological hazards identifiedwithin the workplace.
4. Development and implementation of the CAHS Health and Wellbeing strategy for staff.

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