Government of **Western Australia**
Department of **Health**

Our Ref: LOG21/2243

Hon Roger Cook MLA
Deputy Premier;
Minister for Health; Medical Research;
State Development, Jobs and Trade; Science
Level 13, Dumas House
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Hand Delivered

Dear Deputy Premier

INDEPENDENT INQUIRY INTO PERTH CHILDREN'S HOSPITAL

On 3 April 2021, Aishwarya Aswath presented in the Emergency Department (ED) of the Perth Children's Hospital (PCH). Aishwarya succumbed to sepsis and notwithstanding the devastating and unpredictable nature of this illness, her death has naturally led to unimaginable grief for her family and significant soul-searching within PCH and the wider WA health system.

Following the root cause analysis (RCA) conducted at PCH in April/May this year, I initiated an independent Inquiry under section 183 of the *Health Services Act 2016,* which was conducted by Australian Commission of Safety and Quality in Health Care (ACSQHC). The Inquiry was led by Emeritus Professor Les White and supported by a panel whose expertise included paediatrics, emergency medicine, nursing, psychology and the management of hospitals.

I now submit the Inquiry's report for your consideration and for tabling in Parliament as required by the *Health Services Act 2016*.

I would like to thank and acknowledge the extensive and detailed work of Emeritus Professor White, the other panel members and the ACSQHC in conducting this Inquiry.

The 30 recommendations from the Inquiry can be found in the Executive Summary.

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Broadly, the recommendations cover the following themes:

1. the need for the health services to meaningfully engage and partner with consumers in the safety and quality of care we provide;
2. the need to recognise parental input and to ensure robust care escalation processes across all WA hospitals;
3. the need to strengthen clinical governance processes including further education on clinical incident management and learning from these;
4. the need to ensure adequacy of the nursing and medical workforce supply;
5. the need to improve the physical capacity of the PCH ED, improve patient flow processes across the whole hospital;
6. the need to streamline the organisational structures with better engagement between ED, other service departments and management;
7. the need to better understand and address the needs of CALD patients and their families;
8. the value of information sharing and collaboration between paediatric hospitals.

The Child and Adolescent Health Service (CAHS) has accepted all the recommendations. A letter from the CAHS Board is attached to the Inquiry outlining their response.

Likewise, the Department of Health (DOH) also accepts all the recommendations and will work with all Health Service Providers (HSPs) to diligently implement all those recommendations that are applicable across the WA health system. I wish to acknowledge the significant work which has been undertaken by CAHS/PCH and all their staff to address the recommendations of the original RCA and further comprehensive work that has already been started as outlined in their response.

The Inquiry also identified that PCH had an exemplary record against measures of ED performance and other national safety and quality metrics such as hospital acquired complications. It has led the country in many such indicators and, despite the increased hospital activity, has continued to do so.

In addition, the Inquiry recognised that the WA Health system publicly reports all SAC1 incidents back to 2012, which allows for the sharing of lessons learnt from RCAs across the system. The Inquiry found that these proactive approaches should be encouraged. The transparent reporting of safety and quality performance in health systems is key to continually improve the care that health care systems provide. Whilst other health care systems may not report as freely, WA Health will continue to be open and transparent in reporting our safety and quality performance.

The Inquiry also recognised the extraordinary toll Aishwarya's death has had on her family, as well as on the PCH staff and wider health care community. The ensuing Australian Health Practitioner Regulation Agency (AHPRA) referrals and scrutiny have further impacted CAHS staff. The CAHS Board is cognisant of the need to address staff wellbeing and culture in the light of this tragedy and are working to further enhance patient safety cultures and capability. It is also committed to enacting the Inquiry's recommendations to engage with Aishwarya's family in a process of open disclosure and dialogue.

Aishwarya's death is a tragedy for her family. I have met with Aishwarya's parents, Aswath and Prasitha, to listen to them, and hear directly from them about their experiences and to assist them as the Inquiry proceeded. The implementation of Aishwarya's CARE Call throughout the WA health system, which has been largely completed, coupled with other changes, will be an enduring and lasting memory of Aishwarya.

The WA health system will continually strive to improve the care it provides and fully support our committed staff to achieve this goal.

The DOH and CAHS will update you regularly on the implementation of the recommendations, as they are implemented within CAHS and the broader health system.

Yours sincerely

Dr D J Russell-Weisz
DIRECTOR GENERAL

08 November 2021

Att: Combined Copy of Independent Inquiry into PCH and CAHS Response Statement