PERTH CHILDREN'S HOSPITAL — AISHWARYA ASWATH

Matter of Public Interest

THE SPEAKER (Mrs M.H. Roberts) informed the Assembly that she was in receipt within the prescribed time of a letter from the Deputy Leader of the Liberal Party for seeking to debate a matter of public interest.

[In compliance with standing orders, at least five members rose in their places.]

MS L. METTAM (Vasse — Deputy Leader of the Liberal Party) [3.14 pm]: I rise in support of this motion. I move —

> That this house condemns the Labor government for dangerously under-resourcing the health system at Perth Children's Hospital, which underpinned the tragedy surrounding Aishwarya Aswath, and calls for the Minister for Health to resign for failing to acknowledge and act on the warnings from health workers, the Australian Medical Association and the Australian Nursing Federation.

I would like to start my comments on this motion by acknowledging the tabling of the report of the independent inquiry into Perth Children's Hospital. We certainly welcome the recommendations. We also welcome the government's support for the implementation of the 30 recommendations made today. I would also like to acknowledge the family and friends of Aishwarya. I acknowledge the heartbreak and grief that they have had to endure since her death and the strength that they have shown to continue to seek answers and changes in the health system in honour of her legacy.

As the Minister for Health would be aware, it has been seven months since the tragic death of seven-year-old Aishwarya Aswath. It has been seven months since this little girl was taken to our flagship children's hospital by her distressed parents, who were seeking help. It has been seven months since she was left to wait in the emergency department in her parents' arms as they pleaded for staff to review her and help her before those pleas were finally acted on. It has been seven months in which we have heard from the parents, Australian Nursing Federation, Australian Medical Association and the community who have been seeking answers. It has been seven months of promises from the health executives and the Minister for Health—promises to honour her memory and find answers. It has been seven months in which we have heard that staffing was not an issue in relation to this tragedy, and we heard it today, members, in question time. However, today, this report makes it clear that staffing and the under-resourcing of the health system—not only at Perth Children's Hospital that night—and other issues had been raised. The report makes it abundantly clear that staffing most certainly was an issue.

Some of the findings from the report of the independent inquiry, which has been tabled today, point to the staffing issues. In response to the minister's answer in question time today, I refer to staffing numbers on page 35 of the inquiry report, *Inquiry under part 14 of the Health Services Act 2016 (WA): Independent inquiry into Perth Children's Hospital*, which states —

- 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.

We have heard from the parents themselves and we are also very much aware of the issues that were raised by health staff in relation to not only that night, but also October the year before, and since, about the dangerous levels of staffing in that under-resourced emergency department. The pressure on the emergency department due to the significant, unseasonable rise in presentations from October to December 2020 was not able to be met with sufficient urgency and scale. Further contributing factors were the suboptimal levels of contingency resourcing and capacity to respond to unexpected surges in demand. There has been a practice of using ED clinical expert nurses to backfill wards, leaving the ED with fewer skilled nurses as replacements. Critically, the report states that 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. I have already referred to the dedicated staffing of the resuscitation bay, which is also outlined in this report.

This was a report in which the minister was effectively dragged kicking and screaming at every step of the way. The family has continually had to fight for answers every step of the way. The family was so desperate for answers that they staged a hunger strike at Perth Children's Hospital, begging for an independent inquiry after issues were raised that an internal inquiry would not be sufficient. I note the comments from the Australian Medical Association's Andrew Miller in the media today, talking about the fact that the independent inquiry acknowledges the systemic failure of the Department of Health and the leadership in ensuring that the hospital was properly resourced.

The Minister for Health's response to these concerns was extraordinary. I touched on the fact that, from the beginning, the minister has talked about the health system operating magnificently. The minister, in response to concerns

raised, talked about the fact that that reference was in relation to health workers. The opposition then raised the question of why the response was to throw health workers under the bus. While the chair of the Child and Adolescent Health Service was resigning, why was the Minister for Health insisting that the system was performing magnificently in the aftermath of Aishwarya's death? How painful was that for not only the family of Aishwarya Aswath, but also the health workers who had been raising again and again that they were an under-resourced health workforce and that they felt demoralised? They felt demoralised and under-supported. A young girl died after months of warning about the state of the system.

It is clear that in October 2020, senior clinicians had raised serious concerns to senior management about patient safety and they were not addressed. In December 2020, the AMA had a crisis meeting with this government about the lack of access to emergency care and told the government representatives that people were suffering and dying as a result of these issues and that it would get worse. That was the warning made by the AMA at the time but nothing was done. The AMA and the ANF made pleas to address concerns but they were ignored and met with platitudes. Sadly, it has taken the death of a seven-year-old and, further to that, the pleas of those parents, a campaign of health workers and a number of protests for the government to finally acknowledge, in some way, that resourcing was an issue. The decision to refer three clinicians—two nursing and one junior medical officer—to the Australian Health Practitioner Regulation Agency has created further tensions and conflict. The report also points to the poor staff morale. We are not only seeing it at Perth Children's Hospital. We know that only 47 per cent of health workers feel valued, so it is across the system. What message does that send to the health workforce when the first response of the McGowan government minister is to throw those health workers to AHPRA, effectively throwing them under the bus? The independent inquiry also points to the extraordinary handling of the root cause analysis report, most notably the absence of executive team endorsement, along with the later referrals of staff to AHPRA, the unexpected release to the media and the public scrutiny. That did much to damage trust and morale within the health workforce.

Today's findings all point to the same thing—health executives knew staffing was at a critical point and were warned that there would be dire outcomes if nothing was done. It took the death of a seven-year-old to highlight the dangerous level of resourcing. The way this has been handled over the last seven months has also been bitterly disappointing, not only for the family and health workers, but also in the eyes of the public.

We heard the Minister for Health reading from a different script today. He at least admitted in the press conference that staffing in the lead-up to Aishwarya's death was becoming a significant constraint, relying too heavily on casual and pool staff. He also said that at the end of 2020–21, staff were fatigued and working hard and, in the second half of 2020, there was a significant increase in mental health presentations. The root cause analysis findings were also very clear about the staffing issues. It found, among other things, that uncovered sick leave resulted in a reduction of medical staff, which may have contributed to a delay in recognition of severity of the illness inflicted on and felt by Aishwarya, as well as the delay in the initiation of treatment. There was also the need for a model of clinical supervision for all staff, nurses and senior nurses and the importance that they need to go to another role, which results in no supervision of junior nurses. What an impossible position those junior workers who were sent to AHPRA were put in.

Last Friday, I was lucky enough to speak to a nurse at Perth Children's Hospital who now works in the emergency department. She talked about the obvious distress that they feel as health workers. On all sides of the house we know that our health workers do an incredible job in ensuring that patients are prioritised, but the ramifications that it had when the government rolled out junior health workers and the staff in that way, so they were the ones to be scrutinised and disciplined when they were of the body of the workforce raising concerns about the dangerous levels of staffing, has certainly had a significant impact, and an impact that this government has much work to do to turn around. We also heard in the RCA findings that there was incomplete clinical handover between staff, which resulted in non-urgent escalation and a lack of formalised escalation process for families, which resulted in no clear pathway for seeking more senior assistance. After the root cause analysis was released—I have touched on this already—it was not endorsed by the health minister or the executive. We know that the health minister was initially reluctant to initiate an independent inquiry. It was on 25 May this year that the health minister relented after some pressure from the family. He told this house that the independent inquiry would "focus on the specific factors that contributed to Aishwarya's death" and "will be completed within approximately 10 weeks". That certainly did not happen. We heard that this related to border restrictions. We asked questions in this place about that, but the report actually took 25 weeks. Although the issue of border restrictions was raised as the reason for the delay, we know that Zoom meetings were utilised and that there was some border travel for business when it was deemed important enough. I would have thought, given our health system is in crisis, that this inquiry would have been a priority of this government.

The health minister has repeatedly avoided accountability over the timing of the report. He blamed the borders and the importance of not being willing to rush the process. We asked: Will it start next year? When will it finish? We were assured on 25 May that the independent inquiry would provide some thorough analysis. Today, once again

we heard platitudes from the Minister for Health, again deflecting from the real issues that have been highlighted in the report.

The reality is that there is no way to spin this. There is also no way to deflect or divert blame for this. The reality is, despite repeated warnings about the state of the health system, the dire staffing shortages and the exhausted medical staff and low morale, this government did nothing. This government did nothing when those warnings were made in October and December, and also in the aftermath of this tragedy. There was no urgency. There was no action until sometime after. Aishwarya Aswath waited two hours for care. It is clear the health minister ignored the warning signs. It is clear that a line needs to be drawn in the sand so that both staff at Perth Children's Hospital and the family can start the process of healing, as outlined in the inquiry's report. The reality is that the buck stops with the health minister. It is clear from the way he has handled this tragedy and issues around staffing preceding it that the minister is not fit to oversee such an important portfolio. We call for his resignation so the process of healing and rebuilding can begin.

This has been a very tragic incident from the very beginning. It has been painstaking for the opposition to raise these issues in the media and in this place, but these are important matters. It does not come lightly that we call for the Minister for Health to resign. We raise these very sensitive issues on behalf of not only health workers and the public, but also Aishwarya's family. From the very beginning, there was a lag time for the minister to respond. The chair of the Child and Adolescent Health Service stepped down and the CEO offered his resignation, but the minister did not accept any responsibility. The minister did not accept any responsibility despite the fact that issues regarding the dangerous under-resourcing of the emergency department at Perth Children's Hospital were raised on a number of occasions. The outcome has been tragic. The response from the government from the get-go has been lacklustre. That is why the opposition feels there is no other outcome than to ensure that the recommendations are implemented as a matter of urgency, that the family and health workers receive the support that they deserve, and that this important portfolio is given to a someone who is up for the job.

MS M.J. DAVIES (Central Wheatbelt — Leader of the Opposition) [3.35 pm]: I rise to support the shadow Minister for Health's motion and agree that it is time for this minister to go. It is a damning day for the McGowan government, particularly for the Minister for Health. I start by saying that when we raise these issues—I know the minister does it regularly—we are not talking about the staff in our health system. These people turn up to work every day. They have committed their lives to making sure others are looked after at times of great difficulty; they are under great duress. By not investing in our health system, by under-resourcing and stretching those people, this government has put them at risk. They have put our staff at risk and they have put patients at risk. At no point did the opposition bring to this place, or any public place, an argument that the staff who are in the health system should be criticised; quite frankly, they are trying to do more with less. This government has allowed that to happen over the last five years. It is indeed a damning day for the government and this minister because this report, 25 weeks after the incident occurred, shows that the minister has overseen the demise of a health system that we need operating at full capacity. It should not have taken the death of this seven-year-old girl to bring this type of scrutiny and this type of investigation to the fore; to be able to get someone to acknowledge that our system is broken and that it needs urgent attention. It should not have taken that!

The minister should have listened to the warning signs early in the piece, when four or five years ago the opposition started raising concerns about ambulance ramping, code yellows, and what we call the canary in the coalmine; when there are failures occurring on a systemic basis across the health system. That is what should have happened but the government ignored it. Its priorities were not right. It is a fundamental and basic part of a government's duty at the state level to look after our health system and to make sure that it is safe and efficient; and to make sure that the people who turn up to work go home to their families at the end of the day and are looked after. This government has failed. This minister has been in charge the whole time, and before that he was the shadow Minister for Health. He is someone who is very familiar with what is needed to manage our health system. This minister has failed to provide the funding and resources for hospitals, which need to be the centrepiece of our medical system. Parents and guardians, and people who attend these hospitals, need to have great confidence. That confidence has been shaken because of a lack of resources; no more so than for this family, who waited 25 weeks for the outcome of a review. The report findings are tragic. Twenty-five weeks after the tragedy of Aishwarya's death, we finally have the report. It details a litany of system failures. The minister mentioned one of them earlier, which was one of the compounding factors. There were some systemic factors and also some contextual failures. One of them was that shift into a new system—a new emergency department. That can never be an excuse when it comes to looking after our children's health. There needed to be more attention and resources put into making sure that we had that right. I do not think that simply saying, "Well, then COVID arrived" would sit well with any parent who is relying on governments of any persuasion to make sure that investment is made into and support is provided to the staff who are working in that system and making that transition.

The relocation from Princess Margaret Hospital across to Perth Children's Hospital was always going to require investment and resourcing to familiarise and upskill those staff. It was a new environment, there were many moving

parts and there was so much happening. Unfortunately, the report identified that as one of the things that had been underdone. Again, this government did not have the right priorities. The report notes that triage and waiting areas were vulnerable and suboptimally staffed before COVID arrived. There were issues in staffing before COVID arrived, and, on the day this occurred, the staff were, without doubt, stretched beyond their limits. That means that there were not enough staff, and the staff who were there were exhausted and demoralised. The minister knows that this is the case through the surveys that the Department of Health conducts for its own staff. They were demoralised, isolated and on a shift in which they were asked to do too much with too little. Those broader systemic failures that we see across the health system are coming home to roost because this government has failed to invest. This report has highlighted just how precarious our health and hospital system is, at a time when we need it to be operating at full capacity. We have seen the impact that has had on Aishwarya's parents and family, who are left devastated. It has left the hospital staff who were involved devastated. Much work will need to be done to rebuild the confidence of those staff, to ensure that they have confidence not only in the leadership of the hospital, but also that the government has their backs and will continue to invest and make sure that we are not faced with another situation like this.

We all understand that hospitals are complex environments. Tragedies occur, but there is so much that could have been done to avoid or potentially avoid what occurred here. A significant amount of work needs to be done by this government, and not just at Perth Children's Hospital. What about what is happening in our other hospitals? We have had record ambulance ramping under this minister's watch—a 300 per cent increase from our time in government. There are code yellows on a regular basis, indicating that our hospitals are bursting at the seams. There were 490 code yellows between June 2020 and June 2021. The Australian Medical Association's survey backs up the Your Voice survey that the Department of Health carried out and states that every person working in that system is under stress and constantly on eggshells waiting for the next tragedy to occur. There have been rallies outside Perth Children's Hospital with the doctors, clinicians and midwives venting their concerns because they cannot get the minister and the government to invest where they need to and what has been invested has been too little, too late. We have great concerns now that we are facing the potential emergence of COVID in our community and what this will mean for our health system. We have just seen a budget handed down in which money was invested into the health system, and not four weeks later we saw another announcement. It is a clear indication that this government has underdone the health system for too long. It is a failure of the minister and the government, which has a responsibility to make sure that we are safe and that we have efficient systems for all Western Australians.

As I said, we accept that tragedies occur, and our hearts go out to Aishwarya's parents and family and everyone who has been involved in this. But the minister and the government have failed to resource our health system properly. They have failed to prioritise health, and for that we ask that the minister resign. It is time for someone else to step up and refresh the leadership in our health system, because in this portfolio there are too many fires on the home front. We do not need to go too far out of the metropolitan area to start to have great concerns for our regional communities, which are remote from these specialists, have seen very little investment and are very nervous about the fact that they rely on fly-in fly-out staff who are also stretched to the limit. We have entire hospitals staffed by fly-in fly-out staff. That cannot be the model we rely on when we have COVID on our doorstep and need our hospital system to be working at full capacity.

Minister, you have absolutely failed. This report has been brought down today, 25 weeks after that tragic incident occurred. It is a damning day for the McGowan government and for the minister who has been in charge of the health system up to this point. We need to have reassurance that this government will prioritise health going forward so that when we are faced with similar situations, we are not back here having the same debate again.

MR R.H. COOK (Kwinana — Minister for Health) [3.44 pm]: Deputy Speaker, thank you very much for the opportunity to comment on this debate.

There is a certainly inevitability in this debate. There is certainly a repeat and a constant regurgitation of the same lines and themes that this opposition has come up with throughout this year. The problem is that if members opposite craft their motions and arguments before they have actually read the report, they do not do justice to that report. This is a serious matter. The fact that the opposition treats this with a glaring indifference to the truth is really, quite frankly, an abrogation of its responsibility to provide an appropriate accountability mechanism in this place. The fact that members opposite are so willing to misrepresent what this report actually says and misrepresent the conduct of the government really just gives life to the fact that they have no arguments and no sense of responsibility about the way they conduct themselves.

It is just extraordinary that the opposition should say that we are avoiding our accountability, when we are the ones who did the initial root cause analysis report, which we initiated straightaway. The RCA report said that we should do this inquiry and we launched this inquiry straightaway. The opposition just invents this apocryphal sort of scenario that somehow we were dragged kicking and screaming to the process. It is just not true. In fact, the Liberal Party is lying when it makes these assertions. Members opposite say that we were pushed into it. That is, quite frankly, not true. They say that we did not prioritise health care. That is demonstrably not true. We just need to look at the budget to see that. In 2019–20, we spent $747.890 million on the Child and Adolescent Health Service. In 2021–22, it was

almost $840 million. That is almost a $100 million increase in just three years. It is just plain wrong to say that we are not prioritising it. It does not surprise me that this mob opposite us simply ignores these facts—the cold facts in front of us—as it tries to concoct these scenarios to meet its rhetoric. It is rhetoric that is, quite frankly, not borne out by the facts of this report. In addition to that, members opposite completely ignore the fact of the extra resources that the McGowan government has put in as recently as in the 2021–22 budget, which included an extra $1.9 billion investment into health. Of that, $68.1 million was additional investment across CAHS, which includes a $42 million investment for an additional 278 FTE to be recruited to support the opening of an additional 22 beds and other activity pressures across Perth Children's Hospital, and $26.1 million additional investment into the Child and Adolescent Health Service's community services. This funding includes $4.8 million to support the emergency department as part of our ED support package.

The opposition says that we have never prioritised the children's hospital. We are the ones who actually got it open! The neglect under the mob opposite was there for the entire community to see. We are the ones who actually got it open in the first place. The opposition's mismanagement of the whole project and, quite frankly, its neglect of its responsibility to supervise that project had left this entire hospital floundering. It was only after we got there that we were actually able to open the hospital.

The opposition talks about the lack of staff morale. I have to tell members opposite that morale in that hospital—that is, Princess Margaret Hospital for Children and latterly Perth Children's Hospital—was significantly worse under them. One of my first tasks as Minister for Health was to go to some of the angriest staff meetings, where they were almost at each other's throats. The Child and Adolescent Health Service did a lot of work to boost staff morale, and that was acknowledged in the independent inquiry's report and represented continually in Your Voice in Health surveys. Unfortunately, Your Voice in Health surveys do not go back to the time when the opposition was in office, because the previous government did not have them; it always hid behind these issues. We actually bring up staff morale in Your Voice in Health surveys because we believe in this stuff; members opposite do not. They should not come into this place saying that the government does not want to be accountable. We are the ones who actually produced the survey findings, which the opposition is now trying to quote and, quite frankly, misrepresent.

The fact of the matter is that up until the 2020 Your Voice in Health survey, we saw significant improvements in staff morale and wellbeing in the Child and Adolescent Health Service. There was a dip in 2021, and we know why; there are reasons for that. Staff were tired. They had had to deal with the issues around Aishwarya, so it is not surprising that there was a dip in morale. But members opposite should not come into this place and trash the great work done by CAHS to improve staff wellbeing and morale, because they just do not know. They are not telling the truth. They are doing a disservice to themselves, to this Parliament and to the report, which actually acknowledges that a significant amount of work was being done on these things.

The inquiry found some very significant issues in relation to the series of events that led up to Aishwarya's death on 3 April this year. The report talks about the unprecedented level of activity at that hospital, particularly at the back end of 2020. We know that throughout 2020 activity had reduced in a lot of hospitals; nevertheless, staff stress and the anxiety associated with COVID-19 was still being felt by our teams on the front line. When there was an increase in activity at the back end of 2020, obviously the impact of that activity was compounded by the fact that staff were already stressed and fatigued. Of course, COVID-19 impacted our ability to recruit and grow our staff numbers. Traditionally in Western Australia, we have relied upon overseas and eastern states–trained doctors and nurses to supplement the ranks in our hospitals. It is not an aspect of our health system that I am particularly proud of, but it is a fact that we rely upon doctors and nurses, particularly from the UK and Ireland, to come to Western Australia to practice in our hospitals, albeit sometimes for just a year or so, as part of their life experiences. The tap of that rich vein of doctors and nurses was obviously switched off in the wake of COVID-19, and that led to staffing difficulties.

It is not a fact that we were not doing work in response to staffing issues; a lot of work was being done, and we saw an uptick in numbers. From October onwards a lot of work was done to work with staff to actually understand what we needed to do to supplement our numbers of doctors and nurses, particularly in our EDs. I was not part of those discussions; these are discussions that go on between clinical teams and their health leaders all the time, but those discussions were part of the experience of that ED in the second half of 2020. We also had a particularly high incidence of respiratory syncytial virus in our community that was not reflected on the east coast, because of course they were in lockdown. In Western Australia we were celebrating relative freedom compared with the east coast, so we had a higher incidence of infectious diseases—in this particular case, RSV—which had a strong impact on our EDs. In addition to that, we also had a high presentation rate of adolescent mental health issues, and that also had an impact. It meant that around the October quarter of 2020, the Perth Children's Hospital's ED was the busiest paediatric ED in the country, so it is not surprising that the system was under stress.

Some of these issues, particularly around the configuration of staffing, were further complicated by the design of the ED. When the teams moved from Princess Margaret Hospital for Children to Perth Children's Hospital, they obviously welcomed the opportunity to go into a brand new, larger ED that would provide an important new phase

for the Perth Children's Hospital. Between late 2018 and 2019, they realised that the design of the ED produced some constraints that then had implications for staffing. One of the outcomes of that was a recommendation to redesign the ED in a manner that made it more efficient and more workable. That work was commissioned in early 2020 as part of our efforts to continue to improve the ED and the way it functioned. Of course, the work was interrupted by COVID-19 and then further interrupted by the incident with Aishwarya in 2021. That work has now recommenced following the issuing of the report into that evening.

As Professor White acknowledges in his report, a range of issues led towards the circumstances of late 2020 to early 2021. I note that throughout this period the Perth Children's Hospital was still performing at the same level or better as the vast majority of paediatric emergency departments in the country. Again, this is a point that Professor White makes. Whether it is the four-hour rule; the WA emergency access target, or WEAT, as it is known here; length of stay; admission rates; infection complications; or adverse events, Perth Children's Hospital, and particularly the ED, has performed in a manner about which we should all be very proud. The fact is that it has performed extremely well. Indeed, in January and February 2021, the WEAT targets were extremely high—in the high 80s. Even though hospital staff were experiencing these pressures and the fatigue that goes with them, they were still doing an incredible job—or a magnificent job, as I have been accused of saying. We are therefore rightly very proud of the work they did.

Obviously, the circumstances around the passing of Aishwarya in the care of Perth Children's Hospital is incredibly concerning; it is the outcome we least want and that we most fear, but we cannot shirk the responsibility of responding to that situation and making sure we learn from it. That is why we have had this independent inquiry. I will add that we will also have a coronial inquiry in the first half of next year, which will shed further light on the situation. Despite the member for Vasse suggesting that we are shirking our responsibilities and avoiding scrutiny, we are actually putting the full torch of daylight on this matter to make sure that we can continue to learn from it.

I want to refer back to staffing for a moment and the member for Vasse's accusation that the government threw the staff under the bus by referring them to the Australian Health Practitioner Regulation Agency.

Mr P.J. Rundle: Absolutely.

Mr R.H. COOK: Is that the member for Roe's accusation as well, by way of interjection? This is the problem, when we have an opposition that is so ignorant and so lazy that it is incapable of actually trying to find out the truth of the situation. These staff were referred to AHPRA by the hospital leadership. It had nothing to do with the government. Section 146 of the Health Services Act sets out very strict circumstances under which a staff member—regardless of whether they are a doctor, a nurse or an allied health worker—should be referred to AHPRA.

Mr V.A. Catania interjected.

Mr R.H. COOK: We listened in silence to the lies from members of the Liberal Party. I think it is only right that they should listen to us and learn something for a change.

Mr V.A. Catania interjected.

The ACTING SPEAKER (Ms R.S. Stephens): Members!

Mr R.H. COOK: Section 146 of the Health Services Act requires a health service manager to refer a member of staff at a very low threshold. It does not confer guilt. It does not assign responsibility. It is simply saying to AHPRA that there is an issue that it should be aware of and it should inquire as it sees fit. It has nothing to do with the government. The only time it relates to the government is in the crafting of the legislation. Governments in Western Australia have been criticised by people who say that under this act, the threshold for reporting is too low. That is the former government's legislation. This is not our legislation at work. The important issue we need to remember is that we do not confer guilt, we do not judge and we do not assign any responsibility in relation to that. We simply say that the hospital or the health service manager is complying with an act of Parliament that the former government brought into being.

The other thing that we also have in this state is a very low threshold in the reporting of severity assessment code 1s—that is, adverse events or near misses. No other jurisdiction in Australia reports near misses. That is a characteristic of the WA health system. It is another sign that rather than trying to dodge critique or scrutiny, as the opposition accuses us of doing, we invite that critique and scrutiny by virtue of the fact that we want our system to be open and accountable. That is what SAC 1s are about. That is why root cause analyses, which are consequential to SAC 1s, are put in place. Again, Professor White has commended the WA health system for including near misses as part of our SAC 1 regime. Again, it is not a question of avoiding this responsibility; it is about embracing it. What have we done in relation to this particular issue? We have agreed to and are implementing all recommendations from the root cause analysis investigation that took place. That process is ongoing. It includes the rollout of what is called Aishwarya's CARE Call, which is an escalation opportunity for parents or carers of people in paediatric EDs or anyone that they are looking after really—it does not have to be a paediatric ED—and that has been rolled out across all hospitals. Again, Professor White commended us for implementing that particular requirement.

In addition to implementing the recommendations of the root cause analysis investigation, we are partnering with the Australian Nursing Federation to implement its 10-point plan that was organically developed in consultation with clinical staff and, obviously, the nurses primarily, in the PCH ED. We are working with the ANF to implement every item of that 10-point plan. Rather than ignoring the ANF, as the opposition accuses us of doing, we are working with it very closely, and with the Australian Medical Association, to identify all these issues and try to resolve them in a collaborative partnership way. Again, Professor White commended the health system for working closely with the ANF on this 10-point plan. He saw this as a really positive development.

The report made 30 recommendations, all of which have already been embraced by the CAHS executive and by the government. We will now set about implementing those recommendations as a matter of priority. The director general of Health will report to me regularly on the implementation of these recommendations because we want to continue to make sure that we learn and improve from these experiences. We want to continue to work with Aishwarya's family. Today I spoke with Aishwarya's father, Aswath, and recommitted ourselves to working with the family to make sure that we understand their perspective and aspects of the report that may not have been picked up, brought to life or emphasised as much as they would have liked.

The opposition gave a lot of critique around staffing and staffing shortages. As I said, a range of circumstances led to the situation that occurred that evening, which included the busyness of the ED, the fact that staff recruitment was constrained and the ongoing efforts to reconfigure the staff in the ED to make sure that it better reflected a smoother operation, given the new design features. The opposition raised these issues with one purpose and one purpose only—that is, to try to conflate those issues with the staffing arrangements on the evening. From the perspective of complete clarity, I make it clear to everybody that on the evening in question, a full roster of staff was working. Some called in sick and others were drawn either from other parts of the hospital or from the pool to make sure that we had a full roster on that evening. That is not to say that it was therefore the staff's fault. We will continue to examine the set of circumstances and learn from this. The staff do the very best they can under very difficult circumstances. One of the most difficult circumstances that staff confront in any ED is a patient who is presenting with symptoms that look like a bad flu, but they are really demonstrating the onset of sepsis. Sepsis is a particularly nasty and vicious disease and it is very difficult to diagnose. A lot of work has been done on sepsis, not only nationally, but also at PCH, to continue to refine the protocols to assist staff to better identify sepsis when cases present. Child Health Australasia, the college of paediatric hospitals in Australia and New Zealand, tried to work through a protocol but it was unable to reach consensus. The PCH ED was working on its own protocol to continue to make sure that it informed and supported staff in the way they examined and investigated people presenting with symptoms that ultimately may prove to be sepsis. That work is continuing today. I commend all the staff who are involved in this important diagnostic tool because it will continue to serve us well.

In conclusion, I wish to say that if the opposition alleges that our priority is around budgets, it can see that we have significantly increased the budget, and it is a priority. If it is about close management, supervision and oversight of the hospital, we are the ones who brought this hospital into being. We worked assiduously with all the hospital leaders to make sure that the commissioning was smooth. We made that a priority. We continue to make safety and quality a priority of all our hospitals. We cannot always get it right. Hospitals cannot always get it right, but they can always learn. We will continue to learn from this experience, provide answers to those who were impacted by it and make sure that we continue to support our staff through that learning process to ensure as best we can that it never happens again. We are working hard. The staff is doing an amazing job under difficult circumstances. They are to be commended. They are to be supported. Once again, on behalf of everyone, I pass on our condolences to Aishwarya's family and thank them for their incredible contribution to this inquiry and for their ongoing assistance to ensure that to the extent that we can this does not happen again to another young family.

MR M. McGOWAN (Rockingham — Premier) [4.09 pm]: Firstly, I also pass on my and the government's sympathy once again to the family of Aishwarya on what occurred. Obviously, it was a very, very tragic and devastating situation for them. No doubt we all feel very deeply for the family.

Secondly, the government will not be supporting the motion. The motion refers to "resourcing of the health system at Perth Children's Hospital". The Child and Adolescent Health Service is the overarching body that funds Perth Children's Hospital. The overwhelming majority of the funding that goes to the Child and Adolescent Health Service goes into the children's hospital. In the budget before this government was elected, that was $590 632 000. The budget is now $839 857 000. It went from $590 million to $839 million. That is a significant increase in the budget each and every year over the course of the last five years, including, in some years, budget increases of 14 per cent, eight per cent and above. They are very, very significant increases in the funding for Perth Children's Hospital. Therefore, the fundamental basis of the motion is wrong. This government has put in place huge increases in funding for the children's hospital.

Thirdly, as I think the minister pointed out very eloquently, Perth Children's Hospital sat empty for years, and we put in place the necessary testing regime and made changes that allowed us to open the children's hospital. That is a significant contribution to the health of children around Western Australia.

Fourthly, as the report pointed out, due to a range of factors, staff in the hospital were—I think the word used was "tired" or "exhausted". No doubt, the staff are very tired. We understand that and have been doing our best to recruit additional people to support the staff in the children's hospital. The problem has been that a lot of our recruitment of medical staff takes place overseas. With all the disruption and border closures, the difficulty of recruiting staff from overseas has been there for all to see. Obviously, there has been huge demand for health services staff around the world, including in Britain, which is where we get a lot of our staff from, because it has had massive disruptions to its health systems. Staff recruitment has been disrupted for reasons beyond the government's control, and I think most reasonable people would understand that.

As Professor White pointed out in his commentary, on the night in question the hospital was not understaffed. The emergency department was not understaffed; it had its full complement. Professor White was asked that question today, and that is what he had to say: it was properly staffed on the night in question. Therefore, what happened? I think it has to be pointed out here that poor Aishwarya was suffering from sepsis, which is a life-threatening condition. Each year, 55 000 Australians get sepsis and 8 700 die. So you have a one in six chance of dying if you acquire sepsis in a country like Australia; it is that deadly. Another point about sepsis is —

Ms L. Mettam interjected.

Mr M. McGOWAN: I am talking about the death of a little girl; please.

Sepsis is a very, very awful condition. The signs of sepsis—fever, confusion and a higher heart rate—often can be diagnosed as other conditions because they reflect other conditions. On the night in question, poor Aishwarya was suffering from sepsis, which is a very difficult to diagnose condition and also very, very deadly. Sepsis is an awful and terrible condition for people to suffer from, and when it occurs, it can result in a very rapid decline. That is what the medical evidence shows. I think that was a very sad situation for Aishwarya and her family and explains a lot of what occurred on that night.

Madam Speaker, we will not be supporting the motion. I think this is an unnecessary politicisation of what has gone on. The report sets out a lot of good information and ways to improve things. Obviously, we want to support the family and the hospital through this difficult period. We are massively increasing the resourcing and the staffing to that hospital and more broadly across the health system.

Division

Question put and a division taken, the Acting Speaker (Ms R.S. Stephens) casting her vote with the noes, with the following result —

Ayes (6)

Mr V.A. Catania	Dr D.J. Honey	Ms L. Mettam	
Ms M.J. Davies	Mr R.S. Love	Mr P.J. Rundle *(Teller)*	

Noes (47)

Mr S.N. Aubrey	Ms M.J. Hammat	Mr D.R. Michael	Ms A. Sanderson
Mr G. Baker	Ms J.L. Hanns	Mr K.J.J. Michel	Mr D.A.E. Scaife
Ms H.M. Beazley	Mr T.J. Healy	Mr S.A. Millman	Ms R.S. Stephens
Dr A.D. Buti	Mr W.J. Johnston	Mr Y. Mubarakai	Mrs J.M.C. Stojkovski
Mr J.N. Carey	Mr H.T. Jones	Ms L.A. Munday	Dr K. Stratton
Ms C.M. Collins	Mr D.J. Kelly	Mrs L.M. O'Malley	Mr C.J. Tallentire
Mr R.H. Cook	Ms E.J. Kelsbie	Mr P. Papalia	Mr P.C. Tinley
Ms L. Dalton	Ms A.E. Kent	Mr S.J. Price	Ms C.M. Tonkin
Ms D.G. D'Anna	Dr J. Krishnan	Mr D.T. Punch	Mr R.R. Whitby
Mr M.J. Folkard	Mr P. Lilburne	Mr J.R. Quigley	Ms S.E. Winton
Ms K.E. Giddens	Mr M. McGowan	Ms M.M. Quirk	Ms C.M. Rowe *(Teller)*
Ms E.L. Hamilton	Ms S.F. McGurk	Ms R. Saffioti	

Question thus negatived.