Independent Inquiry into Perth Children's Hospital (PCH) – Terms of Reference

Background

On the direction of the Minister of Heath (WA), the West Australian Department of Health Chief Executive Officer (Director General) has determined that an Inquiry will be conducted into the Child and Adolescent Health Service in respect of all the functions and operations of Perth Children's Hospital concerning the care of Aishwarya Aswath.

This Inquiry is established under part 14 of the *Health Services Act 2016*.

On 3rd April 2021 seven-year old Aishwarya Aswath presented to Perth Children's Hospital (PCH) Emergency Department (ED) with fever, lethargy, diarrhoea and vomiting. She died within hours of Group A Streptococcal sepsis.

The recent Root Cause Analysis (RCA) recommended an independent Inquiry of the PCH ED.

Terms of Reference

The aim of the Inquiry is to focus on the specific factors which contributed to Aishwarya's death in the ED on 3rd April, and more generally the approach to clinical governance, risk and adverse incidents at PCH.

The specific terms of terms of reference are as follows:

The 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.

Conduct of the Inquiry

The Director General will appoint an Inquirer from the Australian Commission on Safety & Quality in Health Care (ACSQHC). The inquiry team will include:

- medical and nursing leads with tertiary hospital experience of paediatric emergency medicine;

- members with experience in clinical governance, safety investigations (human factors) and medical administration;
- a WA-based clinician, approved by the Inquirer, who is not from PCH and who has had no involvement in this matter to date.

A representative will be nominated by the Aswath family.

Initially the inquiry team will interview the Aswath family. Further input will be sought from PCH clinical, administrative, executive staff and the CAHS Board; and if thought necessary, additional information may be sought from other consumers and carers. Relevant documentation and data will be made available to the inquiry team.

Term

A report of the inquiry, detailing the findings, conclusions and recommendations, will be completed within approximately 10 weeks of the commencement of the Inquiry.

The report will be provided to the Aswath family, the Child and Adolescent Health Service Board and Chief Executive, and the Director General who may all provide comments on the report.

The report will be submitted to the Minister for Health for consideration, and for tabling before each House of Parliament.

24 May 2021