Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 2/17

I, Sarah Helen Linton, Coroner, having investigated the death of ***Masaly MOSBY*** *with an inquest held at the* ***Broome Courthouse*** *on* ***9 – 10 January 2017*** *find that the identity of the deceased person was* ***Masaly MOSBY*** *and that death occurred on or about* ***6 October 2011*** *at* ***House 11, Kennedy Hill Aboriginal Community, Broome*** *as a result of* ***acute necrotising pneumonia*** *in the following circumstances:*

Counsel Appearing:

Ms F Allen assisting the Coroner.
Mr B Nelson (State Solicitor's Office) appearing on behalf of WA Country Health Service, Ms Hanley, Ms Cahill, Ms Fleischer and Dr Phillips
Ms B Burke appearing on behalf of Nurse Conder.

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INTRODUCTION

1. Masaly Mosby was born on 1 September 2011 at Broome Hospital. She was released from hospital into the care of her mother two days later. At that time she was in good health. She was seen by a child health nurse a number of times in the following weeks and there were no concerns about her health. Approximately one month later Masaly became unwell and was taken to Broome Hospital by her mother on 2 October 2011. She was discharged home after being assessed by a doctor. Masaly was taken back to Broome Hospital twice more in the following days but did not see a doctor for various reasons, before she died at home sometime overnight on 5 to 6 October 2011. She was only 36 days old.

2. On 31 March 2015 the State Coroner concluded that it was desirable that an inquest be held into Masaly's death and granted approval for an inquest to be listed. I held an inquest at the Broome Courthouse on 9 and 10 January 2017.

3. The documentary evidence tendered at the inquest comprised a comprehensive report of the death prepared by the Western Australia Police.[1]

4. The oral evidence given at the inquest focused primarily on the care provided to the deceased at Broome Hospital on the three occasions she attended in early October 2011 and the reasons why the pneumonia that caused her death was not diagnosed and treated. Evidence was also heard about changes to procedures that have been implemented by the Western Australian Country Health Service (WACHS) at Broome Hospital since Masaly's death that are intended to avoid a similar possibly preventable death occurring.

THE PREGNANCY AND BIRTH

5. Masaly's mother had an uncomplicated pregnancy although she did require antibiotics for a period of three weeks during the pregnancy for a urinary infection. She admitted she smoked

[1] Exhibit 1.

cigarettes and cannabis regularly during the pregnancy, but abstained from drinking alcohol.[2]

6. Masaly's mother gave birth to Masaly on 1 September 2011 by vaginal delivery. At that time Masaly was at an estimated gestation of 39 weeks. Masaly's Apgar scores were 9 (out of a possible 10) at both 1 minute and 5 minutes.[3] Her birth weight was below average, at 2.62 kg but within the normal range,[4] and she was well and had no obvious abnormalities at birth.[5]

7. Following her birth, while still in hospital, Masaly was noted to be doing well and the only significant issue of concern was that she was found co-sleeping in her mother's bed under the bed covers. Co-sleeping (when a parent or carer is asleep with a baby on the same sleep surface) is a risk factor for sudden unexplained death in infancy (SUDI) and is generally counselled against by health practitioners in Australia.[6] Accordingly, nursing staff discussed safe sleeping practices with Masaly's mother and she was encouraged to settle her baby in the cot beside the bed.[7]

8. Masaly was assessed and considered to be ready for discharge from hospital on 3 September 2011. Masaly was sent home with her parents that day. At the time of discharge from hospital Masaly's mother was breastfeeding comfortably and there were no health concerns for mother or baby.[8]

9. Once at home Masaly generally slept in a pram next to her mother's bed, although she also sometimes co-slept in the main bed.[9] A child health nurse visited Masaly at home on five occasions in September, which was more often than usual, as Masaly's mother did not wish to visit a general practitioner. Masaly was slow to gain weight so she was changed from breast to bottle feeding and her weight gain improved.[10]

[2] Exhibit 1, Tab 9 [4] – [7].
[3] Exhibit 1, Tab 22.
[4] Exhibit 1, Tab 8, p. 1.
[5] Exhibit 1, Tab 5 and Tab 22.
[6] Exhibit 1, Tab 8; see https://rednose.com.au/section/safe-sleeping.
[7] Exhibit 1, Tab 22, Maternity Integrated Progress Notes, 2.9.2011, 0325.
[8] Exhibit 1, Tab 22.
[9] Exhibit 1, Tab 9 [19] – [20].
[10] Exhibit 1, Tab 5B.

FIRST PRESENTATION TO HOSPITAL – 2.10.2011

10. Around 30 September 2011 Masaly began to develop a cough, which would wake her when she was sleeping.[11] By 2 October 2011 Masaly's parents decided to take Masaly to the Broome Hospital for medical assessment as Masaly still had a cough and had also developed a fever and "didn't seem to be breathing very well."[12] Masaly was 32 days old at this time.

11. Masaly presented at the hospital at 6.15 pm. She was seen immediately by Registered Nurse Daniel Conder for triage. The presenting complaint was recorded as fevers overnight. Masaly was noted to have been feeding normally and had wet nappies but she was vomiting yellow vomit.[13] Her bare weight was 2.94 kg, showing normal weight gain from birth. Her triage observations included a normal temperature of 37°C, a respiratory rate of 40 per minute, heart rate of 185 beats per minute and oxygen saturation of 97% on room air. The recorded heart rate of 185 was above normal limits (tachycardia). The rest of the observations were normal.[14]

12. Nurse Conder acknowledged in his statement that the pulse was high and indicated that his usual practice would be to discuss this with a doctor when able to do so. He is not able to recall now whether he did, in fact, do so.[15] He agreed at the inquest that he would not describe her pulse as unremarkable, so the fact that he had ticked that box on the triage form must have been a mistake.[16]

13. Nurse Conder gave Masaly a triage score of 3, based on her observations and because he had been told that when triaging babies at Broome Hospital babies under three months old they were to be automatically allocated a triage score of 3 to ensure they did not wait for extended periods in the waiting room.[17]

14. Masaly was assessed at 7.00 pm by Dr Murtaza Khanbhai. Dr Khanbhai is a general practitioner who is experienced in

[11] Exhibit 1, Tab 10 [22].
[12] Exhibit 1, Tab 9 [26] and Tab 10 [25].
[13] Exhibit 1, Tab 22, ED Triage Assessment 2.10.2011.
[14] Exhibit 1, Tab 8, p. 1 – 2.
[15] Exhibit 1, Tab 26 [10].
[16] T 54.
[17] T 54; Exhibit 1, Tab 26 [12].

working in Emergency Departments and delivering babies. Dr Khanbhai is based in New Zealand but was working as a locum District Medical Officer at Broome Hospital in the Emergency Department for a three week period during August/September 2011.[18]

15. When he arrived for the examination she was breast feeding and was noted to be feeding well and seemed content on the breast.[19] Dr Khanbhai took a history from Masaly's mother of the birth and recent events. Dr Khanbhai understood from the history given that Masaly had spiked temperatures and was vomiting.[20] She had had several wet nappies during the day and Dr Khanbhai explained to Masaly's mother that she should continue to breastfeed frequently, rather than just on demand.[21] He asked Masaly's mother what was her main concern, and she indicated it was Masaly's temperature.[22]

16. After Masaly stopped feeding Dr Khanbhai examined her. On examination Masaly had a normal temperature, was not dehydrated or distressed and had no rash. Her ears, nose, throat and chest were unremarkable. Dr Khanbhai's impression was recorded as "?", in the medical notes, suggesting he formed no obvious first impression about her condition. Dr Khanbhai indicated that the first thing in his mind, given Masaly's age, was to eliminate the possibility of infection.[23] He found no evidence of infection in the upper respiratory tract or elsewhere and on that basis he entered a diagnosis of coryza (a viral cold) on the following pages. Masaly's mother recalled that she was told by Dr Khanbhai that Masaly had "the flu."[24]

17. Dr Khanbhai was also asked at the inquest whether he agreed the heart rate of 185 recorded under the triage observations was high and he agreed it was a bit high for a four week old baby.[25] Dr Khanbhai's evidence was, if there had been any other associated abnormal findings then he would have been more worried about the heart rate. However, given Masaly was

[18] T 35.
[19] Exhibit 1, Tab 5A, Interview 10.10.2011, p. 1.
[20] Exhibit 1, Tab 5A, Interview 10.10.2011, p. 4.
[21] Exhibit 1, Tab 17.
[22] Exhibit 1, Tab 5A, Interview 10.10.2011, p. 1.
[23] T 40.
[24] Exhibit 1, Tab 9 [27].
[25] T 36.

breastfeeding and her temperature was only 37 (and it was very hot in Broome at the time) he did not think the heart rate on its own was concerning.[26]

18. Dr Khanbhai did not consider collecting a urine sample at that time or conducting any further investigations. He accepted that in hindsight there might have been some benefit in doing so, or at least keeping Masaly in for a longer period of observation before discharge, but he had reached this conclusion knowing what had happened later.

19. Instead, after reassuring Masaly's mother, he dispensed her some infant Panadol as a precaution in case Masaly became feverish and it was given to Masaly's mother with instructions to give Masaly further doses of 0.6ml four times daily.[27] Dr Khanbhai advised Masaly's mother to bring her back for medical review if she remained concerned, particularly if her temperature increased and didn't go down after giving Panadol, or there were feeding issues. They left the hospital at 7.10 pm.[28]

20. Dr Khanbhai was clear that if he had had the opportunity to review Masaly on her second or third presentation, her re-presentation would have made him think differently about his initial diagnosis.[29] Unfortunately, although Dr Khanbhai was rostered on shift on one of the occasions Masaly returned to the ED, he did not get an opportunity to review her.[30]

21. After returning home Masaly's mother gave Masaly the Panadol regularly. It initially appeared to Masaly's parents that Masaly's condition was improving slightly over the next period of hours. However, by the following day her condition worsened.[31]

SECOND PRESENTATION TO HOSPITAL – 4.10.2011

22. On 4 October 2011 Masaly was brought back to the Broome Hospital Emergency Department, this time by her Auntie Sarah.

[26] T 40.
[27] T 36; Exhibit 1, Tab 9 [27] – [28].
[28] Exhibit 1, Tab 5A, Interview 10.10.2011, p. 1 and Tab 17 and Tab 22, ED Triage Assessment 2.10.2011.
[29] T 36, 40 - 41.
[30] T 37 – 38.
[31] Exhibit 1, Tab 9 [29] – [30].

They arrived at 8.30 pm and were seen by Nurse Cathryn Hanley immediately for triage. Nurse Hanley had been working as a registered nurse and midwife for many years but had only been working at Broome Hospital for approximately one month at this time.[32] Nurse Hanley recalls that she asked where Masaly's mother was, and made a note indicating she was told the baby's mother was playing cards.[33]

23. Nurse Hanley was not aware at the time she assessed Masaly that it was her second presentation to the hospital within a few days.[34] Her only way of finding out that information would have been from Masaly's aunt, and she did not mention it to her.[35]

24. Nurse Hanley recalls seeing that Masaly was a very young baby and took that into account in how to triage her.[36] The presenting complaint was recorded as a cough and "breathing funny."[37] Masaly was noted by Nurse Hanley to have nasal flaring and a 'funny cry' and her aunt felt she had not been breathing normally for the past two days.[38] At the inquest Nurse Hanley explained that what she described as a 'funny cry' was a sort of "airway-type breathing like a grunt or a stridor" and it stood out to her "as something that was not a normal noise that a child would make."[39]

25. Masalay's temperature was normal. Her heart rate had dropped from the previous presentation to 110 beats per minute and her respiratory rate to 38 per minute, but her oxygen saturation had increased to 100 %. Nurse Hanley weighed Masaly and her weight was recorded as 2.9 kg. She was again given a triage of 3 (which generally indicates the patient should be seen within 30 minutes).[40]

26. Nurse Hanley took Masaly and her aunt to the paediatric bay and left them there to be seen by a doctor. She handed over Masaly's

[32] T 42.
[33] T 43.
[34] T 45.
[35] T 45 – 46.
[36] T 43.
[37] Exhibit 1, Tab 22, ED Triage Assessment 4.10.2011.
[38] T 45; Exhibit 1, Tab 22, ED Triage Assessment 4.10.2011.
[39] T 45.
[40] Exhibit 1, Tab 22, ED Triage Assessment 4.10.2011.

care to the nurse in charge and then returned to her triage duties.[41]

27. At 8.45 pm, after waiting for only 15 minutes, Masaly's aunt queried the waiting time. She was asked to be patient. Five minutes later, at 8.50 pm (after a total waiting time of only 20 minutes) Masaly was taken from the Emergency Department by her aunt without speaking to nursing staff. Their departure time was recorded by a nurse on the triage form and the entry DNW (shorthand for indicating the patient 'did not wait') was noted in the diagnosis section.[42] As a result of their departure, Masaly was not seen by a doctor during this presentation. It is not clear from the evidence whether Masaly's parents were aware that she was taken to hospital by her aunt. It is also not clear why Masaly's aunt left the hospital after what was a relatively short wait.

THIRD PRESENTATION TO HOSPITAL – 5.10.2011

28. On 5 October 2011 Masaly's mother noticed that Masaly's cough had returned and her breathing had again become laboured. She was also still vomiting without apparent reason.[43] Masaly's parents were sufficiently concerned that they took Masaly back to the Emergency Department of Broome Hospital that afternoon to be assessed. The evidence suggests it was very busy in the Emergency Department that day. According to Masaly's mother, a nurse checked Masaly and said that her breathing was normal but she would need to wait to see a doctor.[44]

29. The Emergency Department Triage Assessment indicates Masaly presented at 2.50 pm. She was seen by Registered Nurse Conder on arrival, who had triaged Masaly on her first presentation and on this occasion triaged Masaly again.[45] Nurse Conder noted that the shift was very busy. He has little other independent memory of the night and most of his evidence came from relying upon the notes he made at the time.[46] To the best of his memory he did not recognise Masaly or her mother from the earlier presentation when they represented at the hospital that night. If he had done

[41] T 46.
[42] Exhibit 1, Tab 22, ED Triage Assessment 4.10.2011.
[43] Exhibit 1, Tab 10 [29].
[44] Exhibit 1, Tab 9 [33].
[45] Exhibit 1, Tab 5.
[46] T 55; Exhibit 1, Tab 26 [20].

so, his usual practice would have been to make a note that it was a second presentation on the triage assessment form.[47]

30. At the time he saw Masaly the presenting complaint was recorded as a cough and fevers overnight, which were not easing despite regular Panadol over the past three days. Masaly was reported by her mother to be grizzly, not settling and had not been drinking well.[48]

31. Nurse Conder noted that Masaly's airway was patent, her breathing and colour were unremarkable and she was alert and not distressed. Her skin was moist and her pulse was noted to be rapid, which Nurse Conder indicated would have been taken on a pulse oximetry machine, but for some reason no pulse rate was recorded.[49] Other observations were also not recorded, which he attributes to the busy shift.[50] Once again, Masaly was given a triage score of 3 (indicating she might require semi-urgent attention and should be seen by a medical officer within 30 minutes).[51] Although Nurse Conder had no independent recollection of seeing Masaly that night, his evidence was that if she had seemed significantly unwell, or had concerning observations, he would have given a higher triage score. The triage score he gave to Masaly was the lowest he would give for any baby her age who came into the emergency department.[52]

32. At 3.45 pm, almost an hour after their arrival at hospital, Masaly and her mother were taken from the waiting area into cubicle 4 for secondary assessment by Registered Nurse Lisa Fleischer. Nurse Fleischer made a note that Masaly was bottle feeding and not distressed at that time. Although she has no independent memory of events,[53] she believes from the triage notes that she also weighed Masaly at this time. Her bare weight was 2.92 kg.[54] She was not aware this was Masaly's third presentation.[55]

33. Nurse Fleischer was asked whether it was unusual for a baby triaged as a category 3 to wait more than an hour before being

[47] T 55.
[48] Exhibit 1, Tab 22, ED Triage Assessment 5.10.2011.
[49] T 55 – 56.
[50] T 57.
[51] Exhibit 1, Tab 2 and Tab 22, ED Triage Assessment 5.10.2011.
[52] T 58.
[53] T 66.
[54] Exhibit 1, Tab 2 and Tab 22, ED Secondary Assessment 5.10.2011 and Tab 25 [8].
[55] T 70.

transferred to a bay. She replied, "Unfortunately not, no; that occurred quite frequently, I would say."[56] Nurse Fleischer explained that the Broome Hospital Emergency Department was very busy and their resources were often stretched. Nurse Fleischer noted that, compared to her previous experience in other hospitals, the Broome Hospital Emergency Department experienced both a high volume of patients and high level of acuity of patients on a daily basis, particularly during the busy tourism season (as was the case at this time) when the presentations often tripled in number.[57] Dr Phillips also indicated that there is a trend upwards in attendances during peak tourism season, from April to October, and explained that during that time GP appointments in the town are often difficult to get on a daily basis and the hospital becomes the default option for the community.[58]

34. Registered Nurse Rebekah Cahill saw Masaly for another secondary assessment at 5.00 pm and performed a set of observations while Masaly was feeding from a bottle. By this time 70 minutes had elapsed from arrival. Masaly had a temperature of 36.8°C, with a pulse of 140/min, a respiratory rate of 56/min and an oxygen saturation reading of 98% on room air.[59] Similarly to Nurse Conder and Nurse Fleischer, Nurse Cahill was not aware Masaly had presented twice before in the previous days.[60]

35. Similarly to Nurse Fleischer, Nurse Cahill observed that Masaly did not exhibit any difficulty feeding or any respiratory distress, or appear distressed in any other way. However, Masaly's mother indicated to Nurse Cahill that she was worried that Masaly was having difficulty feeding. After advising Masaly's mother that the doctor would not be too long, Nurse Cahill left Masaly and her mother in cubicle 4 and attended to other patients.[61]

36. Approximately half an hour later Nurse Cahill returned to bay 4 and performed another set of observations on Masaly. She recalled that Masaly's mother queried whether Masaly's nose was blocked, as she did not think Masaly was feeding well. Nurse Cahill saw no evidence that Masaly was struggling to breathe but

[56] T 68.
[57] T 68; Exhibit 1, Tab 22 [20].
[58] Exhibit 1, Tab 5, Report [30].
[59] Exhibit 1, Tab 2, Tab 14 and Tab 22, ED Secondary Assessment 5.10.2011.
[60] T 59.
[61] Exhibit 1, Tab 14 [9] and Tab 22, ED Triage Assessment 5.10.2011.

documented this concern in the Emergency Department secondary assessment notes at 4.30 pm so that the doctor would be aware of the mother's concern. At this time Masaly was reaching the end of her bottle and her mother was becoming anxious to get home to get more formula. Masaly's mother appeared slightly restless and anxious to leave.[62] Nurse Cahill indicated in her statement that she offered to make another bottle for Masaly so that they could stay for the doctor's review but Masaly's mother had not responded. Nurse Cahill did not find it easy to interact with Masaly's mother, as Masaly's mother didn't speak a great deal, so she decided to leave her for a short time to give her an opportunity to think about it. When she returned about 10 minutes later Masaly's mother was still anxious to go and had packed up her belongings and was prepared to leave. Nurse Cahill tried to ask her why and she told Nurse Cahill she was not going to wait any longer and intended to go.[63]

37. Nurse Cahill recalls that she advised Masaly's mother against leaving without the baby being reviewed by a doctor. Nurse Cahill explained that the hospital was busy and she would need to wait a short while longer but she was close to being seen as the medical officer only had a couple of patients before her to review. Nevertheless, Masaly's mother said that she was leaving. Masaly's mother stated she would return the next day with Masaly to have her reviewed. Nurse Cahill then documented Masaly's departure at 4.40 pm in the medical notes and the fact that Masaly's mother did not wait and advised the nurse coordinator.[64]

38. Masaly's mother indicates in her statement that she did see a doctor at the hospital on this occasion but he "was talking a lot and was not checking her [Masaly]."[65] Masaly's father also provided a statement indicating that they saw a doctor who "didn't' say very much except that she [Masaly] had the flu."[66] Masaly's mother states she then decided to leave the hospital as the doctor was just talking to them and Masaly was getting hungry and she thought it would take too long to wait for a kettle to boil to warm the bottle at the hospital.[67]

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[62] T 60; Exhibit 1, Tab 14 [10] – [11].
[63] T 60; Exhibit 1, Tab 14 [12] – [13].
[64] T 61 – 63; Exhibit 1, Tab 14 [14] – [16] and Tab 22, ED Triage Assessment 5.10.2011.
[65] Exhibit 1, Tab 9 [34].
[66] Exhibit 1, Tab 10 [32].
[67] Exhibit 1, Tab 9 [34] – [36].

39. The medical records indicate that at 4.30 pm Masaly was seen by a sixth year medical student, Kyran Smith. Mr Smith was in his final year of study at that time and is now a doctor, but I will refer to him as Mr Smith (as he then was) to avoid confusion. Mr Smith says that he introduced himself to Masaly's parents and told them that he was a final year medical student[68] but it seems from their statements that despite that introduction, Masaly's parents mistakenly thought he was a doctor. Mr Smith had previously spent some time in Broome Hospital the previous year but this was his first day back at Broome Hospital in 2011. Mr Smith reviewed Masaly in preparation for Masaly being seen by a doctor, at which time Mr Smith would have presented his assessment to the doctor.[69] Mr Smith chose Masaly as she was one of two patients ready to be seen and he was keen to gain some further experience in paediatrics.[70] Like the other hospital staff who saw Masaly that day, Mr Smith was not aware it was Masaly's third presentation to the Emergency Department in a matter of days.[71]

40. With Masaly's mother's permission Mr Smith took a brief history. He noted down that Masaly had exhibited a cough for three days and experienced difficulty breathing. She was unable to tolerate normal feeds, which her mother thought was because she was having trouble breathing. Mr Smith noted that Masaly's mother needed to make another bottle of formula up. As a result, he cut the history taking short and offered to assist Masaly's mother with organising another bottle. At this stage, he had not had an opportunity to examine Masaly.[72]

41. Masaly's mother told Mr Smith that she needed a kettle and a sink to make the formula bottle. He offered to bring her cups of boiling water but she did not seem happy with this solution and became frustrated. She indicated that she had been waiting over and hour and wanted to leave the hospital to make up the bottle. Mr Smith again offered to help her make the bottle of formula but she was now anxious to leave the hospital. Mr Smith asked if there was something else she needed to do or if she had other

[68] Exhibit 1, Tab 5.
[69] T 76; Exhibit 1, Tab 24.
[70] T 77.
[71] T 78.
[72] T 78.

children but she did not respond to these questions.[73] There is some suggestion in a report that the hospital staff believed a relative was putting some pressure on Masaly's mother to leave, although Nurse Cahill and Mr Smith did not give evidence to this effect.[74]

42. Mr Smith tried to reassure Masaly's mother that it would not be too long before a doctor would see her child but she indicated that she still wished to leave the hospital, saying she would return with Masaly the next day. She then left the hospital with Masaly. All up, Mr Smith saw Masaly with her mother for a period of only about five minutes. He had not had an opportunity to examine her before she left. After Masaly left Mr Smith made a note that Masaly was discharged against medical advice. He cannot recall if he told anyone else at the hospital that she had gone.[75] It appears from the times recorded on the triage form that Nurse Cahill and Mr Smith were both speaking to Masaly's mother within a ten minute period, although neither of them appears to recall discussing the matter with each other.

43. Masaly's parents returned home with Masaly and they spent the afternoon at home. Masaly's mother gave Masaly a bath at about 4.00 pm and noticed that during the bath Masaly was coughing and finding it hard to breathe. She rolled Masaly onto her side and massaged her back to try to get some phlegm out, but nothing came out and Masaly continued to cough. She took Masaly out of the bath and after drying her put her on the bed and lay with her while watching a movie.[76]

44. They stayed home for the rest of the afternoon and evening. Prior to putting her to sleep Masaly's mother gave Masaly two bottles of formula and a 0.6ml dose of Panadol. At approximately 9.00 pm Masaly was put to sleep wearing a dress and nappy. She was placed on her back in her parents' bed next to her mother. Masaly's mother indicated she put Masaly to sleep on their bed, rather than in her cot, as Masaly seemed to sleep better when she was next to her mother and Masaly still had a cough. She

[73] Exhibit 1, Tab 5A and Tab 24.
[74] Exhibit 1, Tab 5, Report [21].
[75] T 79; Exhibit 1, Tab 5 and Tab 22, ED Medical Officer Notes 5.10.2011 and Tab 24.
[76] Exhibit 1, Tab 9 [37] – [41] and Tab 10 [35].

placed Masaly on her right hand side, between herself and the wall.[77]

45. Masaly's mother does not recall Masaly coughing much before Masaly's mother fell asleep, although her breathing was laboured. Masaly's father went to bed at about 10.30 pm and at that time Masaly was still asleep in their bed. She was still lying on her back with her face up and he could see she was breathing. She appeared to him to be fine and he went to sleep next to her, so that she was lying between her parents.[78]

46. Both Masaly's parents then slept through the night. Masaly's mother woke at about 7.00 or 8.00 am. On waking she rolled over to check on Masaly and kissed her. Masaly did not respond to the kiss and Masaly's mother saw Masaly was lying still on her back with her eyes closed, apparently not breathing.[79]

47. Masaly's mother picked Masaly up and cradled her in her arms. She could not feel a heartbeat and Masaly was unresponsive. She woke Masaly's father then ran to the telephone and dialled '000' and requested an ambulance attend as her baby wasn't breathing. After waiting a short period for the ambulance to arrive Masaly's mother decided the wait was too long and instead they went to her grandfather's house for help. He then drove them to Broome Hospital.[80]

48. At 7.28 am Masaly's parents ran into the Emergency Department with Masaly and told hospital staff that Masaly wasn't breathing. Doctors and nurses quickly attended and took Masaly from her parents and began resuscitation attempts. A Paediatric Consultant, Dr De Zordi, quickly attended and examined Masaly. Dr De Zordi identified signs of rigor mortis and other evidence that indicated that Masaly had been deceased for some time. Accordingly, Dr De Zordi made a decision that it would be inappropriate to continue resuscitation attempts and Masaly was declared deceased at 7.40 am.[81]

[77] Exhibit 1, Tab 9 [42] – [50].
[78] Exhibit 1, Tab 10 [34] – [36].
[79] Exhibit 1, Tab 9 [51], [55] – [59].
[80] Exhibit 1, Tab 9 [63] – [72].
[81] Exhibit 1, Tab 22, ED Triage Assessment 6.10.2011 and Tab 16.

CAUSE AND MANNER OF DEATH

49. On 1 September 2011 a Forensic Pathologist, Dr White, performed a post mortem examination. The examination found heavy and congested lungs with features consistent with bilateral pneumonia. There were no other structural abnormalities or obvious pathologies observed at post mortem. Gross neuropathological examination of the brain was normal.[82]

50. Microscopy of sampled tissues showed an acute florid necrotizing pneumonia. Microbiological studies isolated a number of respiratory pathogens, but it was difficult to identify their clinical significance.[83]

51. Toxicological analysis showed a small amount of paracetamol, consistent with the history of Masaly being given infant Panadol.[84]

52. Dr White noted that Masaly was small for her age, with her weight and body length both below the 10th percentile for her age.[85] Dr White also noted the information provided on the mortuary admission form indicated Masaly was co-sleeping at the time of her death; as such, Dr White was unable to exclude a contribution by this factor with regards to the death.[86]

53. At the conclusion of all investigations Dr White formed the opinion that the cause of death was acute necrotising pneumonia. I accept and adopt the conclusion of Dr White as to the cause of death. Although Dr White could not exclude co-sleeping as a contributor to the death, the primary cause of death was the acute necrotising pneumonia.[87]

54. Dr Paul Porter, a Paediatric Emergency Physician who works at Princess Margaret Hospital for Children and Joondalup Health Campus as well as lecturing in paediatrics at the University of Western Australia, was consulted by the Office of the State Coroner to review the circumstances of Masaly's death. Dr Porter commented that the clinical course described in the medical

[82] Exhibit 1, Tab 2 and Tab 3.
[83] Exhibit 1, Tab 2.
[84] Exhibit 1, Tab 2.
[85] Exhibit 1, Tab 2.
[86] Exhibit 1, Tab 2.
[87] Exhibit 1, Tab 2.

notes is in keeping with the early stages of pneumonia/chest infection in a neonate and Dr White's cause of death of acute necrotising pneumonia is consistent with the course as described.[88]

55. Dr Porter explained that the documented history suggests that Masaly experienced a rapid deterioration over the last 12 hours of her life, which is in keeping with the clinical course of this condition where the signs and symptoms may be subtle initially, followed by catastrophic deterioration.[89]

56. Dr Porter also observed that the presence of clinical signs and symptoms over a four day period, combined with the pathological findings, indicate that it is unlikely that the death can be attributed to SUDI (Sudden Unexpected Death in Infancy), although he acknowledged that the observation that Masaly was co-sleeping with her parents raised that possibility. However, the acute necrotising pneumonia on its own was enough to explain Masaly's death, even without any contribution by co-sleeping.[90] Dr Porter explained further at the inquest that he took this position on the basis that Masaly was known to be unwell, so her death could not necessarily be said to be unexpected, and the post mortem found a clear cause, so the death could not be said to be unexplained.[91] Therefore, although there is an association between SUDI's and co-sleeping and it is considered to be a risk factor in those circumstances, in his opinion there was a clear build up to, and explanation for, the death that took it out of that area. Nevertheless, he acknowledged that co-sleeping is not recommended.

57. After considering the expert opinions of Dr White and Dr Porter and noting the cause of death, I find that the manner of death was by way of natural causes.[92]

[88] Exhibit 1, Tab 8, p. 4.
[89] Exhibit 1, Tab 8, p. 4.
[90] Exhibit 1, Tab 8, p. 4.
[91] T 20 – 21.
[92] Exhibit 1, Tab 2.

REVIEW OF MEDICAL TREATMENT PROVIDED

58. Under s 25(2) of the *Coroners Act 1996* (WA), where a death investigated by a coroner, the coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

59. The circumstances of Masaly's death raised the question whether her death due to acute necrotising pneumonia was preventable and, related to that question, whether she should have been admitted to hospital during one of the three occasions on which she presented to the Broome Hospital Emergency Department in the days leading up to her death. Dr Porter provided a detailed written report, and gave oral evidence at the inquest, to assist me in answering these questions, and in considering the public health issues raised by Masaly's death.

60. Dr Sue Phillips is the Senior Medical Office at Broome Hospital. She has a Bachelor of Medicine and Bachelor of Surgery and a Fellowship with the Royal Australian Colleges of GP's, Rural and Remote Medicine and Medical Administrators.[93] Her role is 50 per cent clinical work on the Emergency Department floor and is the overall medical lead for medico-legal matters and clinical governance of the hospital.[94] Dr Phillips was on extended leave from the hospital at the time of Masaly's death. Dr Phillips stated that when she returned from leave after Masaly's death, the staff were still struggling in its aftermath and it was a very important topic for her to address. Dr Phillips prepared a report for the coroner on this matter, based on information obtained from staff as to what occurred at the time, and also providing information on changes that have been implemented since Masaly's death after an internal review.[95] Dr Phillips also gave oral evidence at the inquest. I have taken into account the evidence of Dr Phillips in considering the standard of care provided to Masaly, as well as whether or not there is a need for me to make any recommendations arising out of the investigation into her death.

[93] T 80.
[94] T 80 – 81.
[95] T 82.

First Presentation

61. On the first occasion when Masaly presented to Broome Hospital she was seen by Dr Khanbhai and there was no definite indication that Masaly was seriously unwell, other than the tachycardia. Although her mother reported Masaly had been feverish, her temperature was normal at the time she presented to hospital and her general presentation was unremarkable. The general expert opinion seems to be that Masaly's management by Dr Khanbhai, based upon what was before him and without specialist paediatric experience and training, was not unreasonable. However, there were aspects of the care that could have been improved.

62. As noted previously, Masaly's heart rate was abnormal. Dr Porter explained that tachycardia (a fast heart rate such as recorded here) can be explained by a child being upset or screaming or by fever. With the absence of those features, then Dr Porter explained it is usually a sign of infection, or at least metabolic stress that is often associated in a child of this age with infection.[96] Given all the other observations were normal, Dr Porter indicated that it would not have prompted staff to escalate the case to a medical emergency. However, it would have prompted PMH staff on the Emergency Department Escalation Score to initiate continuous monitoring.[97]

63. As for the lack of any other abnormal observations, Dr Porter acknowledged that when Dr Khanbai examined Masaly she presented well and at that time was afebrile (did not have a fever), which appears to have reassured him.[98] However, Dr Porter noted that fever is not a constant, but rather an intermittent symptom, so in his opinion the suggestion that there had been a fever present previously required a period of observation to clarify this.[99] Dr Porter also observed that the diagnosis of coryza did not account for Masaly's reported fever, vomiting or tachycardia, and was not consistent with the normal examination of her ear, nose and throat and chest examinations.[100]

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[96] T 7.
[97] T 8.
[98] Exhibit 1, Tab 8, p. 2.
[99] Exhibit 1, Tab 8, p. 2.
[100] Exhibit 1, Tab 8, p. 2.

64. As an experienced paediatric specialist, Dr Porter emphasised that Masaly's young age and the fact that she was an indigenous child meant "any description of a fever must be taken seriously."[101] When combined with a reported history of vomiting and tachycardia, in Dr Porter's opinion it would be reasonable to advise admission for observation at this point of the presentation, as there were signs of possible early sepsis. Dr Porter indicated that at Princess Margaret Hospital, it is likely that Masaly would have been kept in for 12 hours overnight to see whether a fever was observed or if the tachycardia was persistent or if there were any localising signs of infection. If signs of fever re-emerged, then a full septic screen would be undertaken and the baby would be put on antibiotics until the results came back.[102]

65. Dr Porter also queried the usefulness of prescribing Panadol in the circumstances. Dr Porter explained that in his view Panadol is appropriate for infants in smaller doses for the purpose of pain relief but he indicated that there is a lot of argument that Panadol is ineffectual for fever, so from a paediatrician's perspective he could see no benefit in giving it to Masaly. However, Dr Porter also noted that Panadol can be given to a child this age quite safely, so there was no suggestion it did her any physical harm. Nevertheless, Dr Porter noted that the problem with giving a child of Masaly's age Panadol to treat fever without a good diagnosis is that it won't assist in identifying the cause of the fever in a timely manner, and it may falsely reassure a parent, who may continue to administer Panadol in the belief it is helping, rather than bringing the child back for prompt further review.[103]

66. However, overall, Dr Porter accepted that Masaly examined well when seen by Dr Khanbhai and a reasonable management plan of review was instituted.[104] Dr Porter emphasised that it was not the management plan he would have done, as a very experienced paediatrician, but he indicated that he could understand how someone not as experienced in the area might have made the decision not to admit Masaly at the time of the first presentation.[105] The difference really comes down to how much

[101] Exhibit 1, Tab 8, p. 2.
[102] T 10 – 11.
[103] T 9 – 10.
[104] Exhibit 1, Tab 8, p. 5.
[105] T 11 – 12.

importance was placed on the history given, in the face of what otherwise might seem to be largely a 'well' baby. From Dr Porter's perspective, "the history is as important as the observations."[106] He emphasised that given the choice between accepting the history or ignoring the history in favour of the baby's presentation, he would choose the worst of the two possibilities and assume that the history was correct and required investigation, given the potential risk.[107] As Dr Porter explained, what paediatricians are trying to do is get to these little ones as early in the course as they possibly can, and they know the observations and history may not happen at exactly the same time, so if one of them is out of sync, they rely upon the more serious of the two until proven otherwise.[108]

67. Dr Phillips' opinion was similar to Dr Porter's in relation to Masaly's initial recorded heart rate of 185, which she suggested would prompt a rapid secondary assessment and referral to a medical officer, both back in 2011 and currently based on the 'rainbow charts'.[109] However, Dr Phillips notes that Masaly was seen by a doctor within the hour of presentation in any event, and she describes the care provided by Dr Khanbhai as adequate and appropriate, based upon the primary assessment that Masaly had no obvious respiratory or circulatory distress.[110] Dr Phillips does not place the same emphasis on the history given as Dr Porter.

68. However, during questioning by me, Dr Phillips accepted that the single observation recording tachycardia required further investigation and should have been repeated before Masaly was discharged.[111] Dr Phillips also accepted that there was a difficulty that Dr Khanbhai's diagnosis didn't match the clinical findings. In those circumstances, Dr Phillips did not agree with Dr Porter's opinion that Masaly should have been admitted, but she agreed that she would probably have kept Masaly in the Emergency Department to do a number of sets of observations, or alternatively have asked Masaly's mother to bring her to the paediatric rapid review clinic the following day.[112] Dr Phillips

[106] T 28 – 29.
[107] T 29.
[108] T 34.
[109] Exhibit 1, Tab 5G.
[110] Exhibit 1, Tab 5, Report [46].
[111] T 89.
[112] T 90.

explained that the Aboriginal Liaison Officers that are now available (as described below) can assist to collect and bring people to the clinic, although that resource was not available back in 2011.[113]

69. In conclusion, I am satisfied that Masaly was seen by a doctor within a reasonable period of time on 2 October 2011 and the medical management provided by Dr Khanbhai was appropriate and reasonable in the circumstances as they were known at the time. Dr Khanbhai himself acknowledged that, in hindsight, there were other things he could have done to reassure himself that Masaly was not developing an infection, and some of those steps have been described by Dr Porter and Dr Phillips. However, given how Masaly presented on that day, his plan for her to go home with her parents, with encouragement for them to return to the Emergency Department if Masaly deteriorated, was not unreasonable.

Second Presentation

70. At the time of the second presentation in the evening of 4 October 2011 Masaly appears to have been significantly more unwell, with the triage notes referring to a cough, abnormal breathing, nasal flaring and an unusual cry. In Dr Porter's opinion, it "is clear at this point that Masaly had deteriorated and had a number of sentinel signs that would require admission, investigation and treatment. These signs include the persistent cough and nasal flaring (indicating increased work of breathing and respiratory distress); family suggesting she had not been well for a 48-hour period; previously reported fever."[114] In essence, she presented as a "very small child with signs of respiratory distress,"[115] which warranted the triage score of 3 that she was given, or even potentially a score of 2.[116] Dr Porter also agreed in questioning that the fact that Masaly was an indigenous child placed her at even higher risk of lethal infection, requiring her illness to be treated in a very proactive manner.[117]

[113] T 90.
[114] Exhibit 1, Tab 8, p. 2.
[115] T 13.
[116] T 13.
[117] T 14.

71. In Dr Porter's view, even without the knowledge that Masaly had presented before, the triage notes on this occasion are abnormal and can be looked at independently.[118] If the previous presentation had been known, then this would simply have reinforced the need for admission.

72. Unfortunately, Masaly's aunt, who had taken her to the hospital, elected not to wait until a doctor was available to assess Masaly. No evidence has been able to be obtained from the aunt as to why she made that decision. Unlike the third presentation, she had not been waiting long when she left. Dr Porter accepted that the brevity of this second presentation was such that it would not be reasonable to expect that a doctor would have seen her in the Emergency Department within that time period.[119] Dr Porter recognised that, as the family discharged Masaly without waiting for a formal assessment, the Emergency Department staff were unable to develop or action an appropriate management plan. However, it raised the issue of how to manage patients who do not wait for treatment. I will come back to this issue later in this finding.[120]

73. Dr Phillips also noted that the second presentation was complicated by Masaly's auntie's decision to take her from the Emergency Department. The initial assessment had not raised any red flags because Masaly's vital signs observations were within normal range for her age group.[121] However, Dr Phillips agreed it would have been appropriate for Masaly to be admitted if she had been seen by a doctor, and Dr Phillips believe that would have been the likely outcome.[122]

Third Presentation

74. At the time of the third presentation to hospital the next day, Masaly's condition had deteriorated further, with an elevated pulse and slightly raised respiratory rate but still no sign of fever while at the hospital. Her skin was noted to be moist, which can be a sign of early circulatory changes although it is not a strong

[118] T 29.
[119] Exhibit 1, Tab 8, p. 5.
[120] Exhibit 1, Tab 8, p. 2.
[121] Exhibit 1, Tab 5, Report [46].
[122] T 90.

discriminator.[123] Masaly's mother reported to the triage nurse that Masaly had had a cough and fever overnight, had been given regular Panadol for three days but remained quite grizzly and was not settling and drinking well.[124] The triage observations were incomplete, in that they did not record the heart rate and oxygen saturation, although Dr Porter indicated this was not unusual in a triage assessment, depending on when and how it was done.[125] It seems from Nurse Conder's evidence that the busyness of the Emergency Department was a factor in this not being completed.

75. This was Masaly's third presentation to hospital in four days and a medical assessment was clearly warranted, particularly since Masaly had not been assessed by a doctor on the previous presentation. According to Dr Porter, it was reasonably clear at this point that Masaly had a significant chest infection for a four week old indigenous child and she should have been admitted at this point, with a septic screen and treatment instituted.[126] Dr Porter acknowledged that Masaly's observations were not particularly abnormal and did not necessarily reflect the severity of the infection at that time. However, Dr Porter also noted that the problem with pneumonia or other infections in a very small child is that "they have a terrific ability to cope until they don't cope at all."[127] Therefore, a quick and rapid deterioration is not unusual, so the history and length of the illness must be given significance along with the observations.[128] Dr Porter also explained that the symptoms, such as fever, can be intermittent.[129]

76. Regrettably, once again Masaly was taken from the Emergency Department by family before she could be medically assessed. This time, however, there was a long delay before being seen, which contributed to the family's decision not to wait. It is apparent from her parents' statements that they felt they had waited a long time and gained the impression from the nursing staff and medical student who saw them during that period that there were no major concerns about Masaly's health at that stage. That appears to be consistent with the evidence of the

[123] Exhibit 1, Tab 8, p. 3.
[124] Exhibit 1, Tab 8, p. 3.
[125] T 16.
[126] Exhibit 1, Tab 8, p. 3.
[127] T 16.
[128] T 16.
[129] T 17.

hospital staff who saw Masaly that afternoon, all of whom were reassured by her normal observations and lack of obvious distress.

77. Dr Porter expressed the opinion that what was required was for Masaly to be seen by the doctor within the recommended thirty minute period suggested by the triage score of 3. Following that, she should have been admitted and undergone a chest x-ray, blood testing, administration of antibiotics and possibly microbiology (such as a nasal swab to look for viruses).[130] It is likely that a chest x-ray would have revealed the underlying pneumonia, prompting appropriate treatment.

78. Dr Porter described the two hour wait on the third presentation as "far too long."[131] In his view an experienced clinician would have been able to make the decision about Masaly needing admission and treatment from a quick overview rather than requiring a definitive full assessment. A formal assessment could then have been done when time allowed.[132]

79. In the report for the coroner prepared by Dr Phillips she referred to the lengthy waiting time and commented that from 70 minutes after the triage score was given the secondary assessment found there were no signs of respiratory distress and Masaly's vital signs were still normal for her age group. In light of that assessment, and subsequent assessments, Dr Phillips suggested there was no longer an urgent need for Masaly to be medically reviewed, particularly taking into account the more critical needs of the other patients in the Emergency Department that day.[133]

80. Dr Porter was asked his view on Dr Phillips' opinion about the staff being reassured by how well Masaly appeared while waiting to suggest the initial level of urgency suggested by the triage score could be downgraded. He disagreed with this suggestion, stating, "No, certainly not, no. This is a child who needs to be seen as…quickly as..allowed. She's not needing resuscitation, but she certainly needs to be seen."[134] In making that statement, Dr Porter emphasised that he had been conscious of the need to

[130] T 17 – 18.
[131] T 19.
[132] T 19.
[133] Exhibit 1, Tab 5, Report [14].
[134] T 19 – 20.

not work backwards from the outcome and instead try hard to approach things from how he would think if seeing the child at the time. Nevertheless, he said he was "quite firm that this should be a 3"[135] on the triage scale and certainly not a 4 or more that might suggest she could wait longer before being seen.[136] In Dr Porter's opinion the nearly two hour wait without seeing a doctor on the third presentation was an "inappropriately long time for a neonate with a triage category of 3 and signs of respiratory illness"[137] to wait to be seen by a doctor.

81. In her oral evidence Dr Phillips clarified that she did not suggest the triage score should have been 'detriaged' in any way, but noted it was a guide only and due to the pressure on resources that day (apparently there were seven other patients in the Emergency Department with a triage of 3 and one with a triage of 2) and the fact that there were "good nursing eyes" on Masaly and they were still not raising a level of concern, the length of the wait did not warrant pulling medical resources from another patient while her observations remained normal.[138]

82. Dr Phillips agreed that Masaly should have been seen by a doctor in the Emergency Department, but places a significant portion of the responsibility for this not occurring on Masaly's mother, who chose to leave the hospital. Dr Phillips does, however, acknowledge the complication of the busy Emergency Department increasing the waiting time.[139] Dr Phillips was certain that if Masaly had been assessed by a doctor on that occasion she would have been admitted.[140] Dr Phillips indicates that nursing staff recalled being concerned about Masaly's mother's decision to take Masaly from the Emergency Department but Dr Phillips expressed the opinion that, apart from calling the Department of Child Protection, there is very little that medical or nursing staff can do in these circumstances to prevent the mother from leaving the hospital. Dr Phillips stated in her report that, particularly where the mother has stated that she would return for review the following day, the least restrictive

[135] T 20.
[136] T 20 – 21.
[137] Exhibit 1, Tab 8, p. 5.
[138] T 83 – 84.
[139] Exhibit 1, Tab 5, Report [46].
[140] T 87.

measure is to assume that the mother will act protectively towards her child and re-present.[141]

83. The difficulty with that proposition is that Masaly's parents were likely to have been influenced by the lack of urgency with which Masaly's case was treated, to reassure themselves that she was not significantly unwell. Accordingly, they would be likely to delay the re-attendance. That is what seems to have occurred in this case, and sadly there was no opportunity to re-present the next day as Masaly died overnight.

84. Dr Phillips accepted that Masaly had an infection at the time she presented to the Broome Hospital Emergency Department on the third occasion, but disputed that it was a severe chest infection or that pneumonia had already developed.[142] She referred to discussions with paediatricians at Broome Hospital that supported her view,[143] although I pointed out to Dr Phillips I could attach little weight to that assertion given the indirect nature of the evidence. Ultimately, Dr Phillips was prepared to concede that Masaly was sick with an infection at the time of the third presentation, but it may not have been the overwhelming bacterial infection that ultimately killed her, given her relatively normal observations. Dr Phillips explained that if Masaly had had a viral infection, it may well have made her vulnerable to the bacterial infection's rapid invasion of her system.[144] This conclusion still supports the view that Masaly should, and most likely would, have been admitted if she had been reviewed by a doctor.[145]

85. An important question arises in this inquest as to whether Masaly's death might have been prevented if she had been admitted at Broome Hospital on any of the three occasions that she presented to the Emergency Department prior to her death? Dr Porter expressed the opinion that the outcome would have been positively influenced, but was not able to go so far as to say her death would definitely have been prevented. Dr Porter explained that if *Streptococcus pneumoniae* (which was found during the post-mortem microbiological studies) was the

[141] Exhibit 1, Tab 5, Report [26].
[142] T 84 – 87.
[143] T 84 – 85.
[144] T 87.
[145] T 87.

causative organism for Masaly's pneumonia, then the course of events may not have changed as it is a very serious and difficult to treat infection. In those circumstances, it is impossible to be certain that the eventual outcome would have been different; however, the institution of intravenous antibiotics and other appropriate treatments would have given her the best opportunity of survival. Dr Porter went so far as to say that he *expected* that she would have survived.[146] However, he could not go so far as to say that she would absolutely have survived.[147]

86. Dr Phillips also addressed the possibility that medical treatment may not have helped Masaly, noting that the acute necrotising pneumonia that caused her death is a bacterial infection that destroys lung tissue. Dr Phillips described the infection as rapid and invasive and noted the sepsis affects all the vital organs. In those circumstances, Dr Phillips acknowledged that Masaly would have had the optimal chance of survival if she had been admitted for observation, but she agreed with Dr Porter that her survival could not be said to be a certainty even if admitted.[148]

CHANGES IMPLEMENTED SINCE MASALY'S DEATH

87. Accepting that Masaly's mother could not reasonably be prevented from leaving the hospital with Masaly that night, an issue arose in this inquest as to whether some follow up should have been attempted after Masaly left the Emergency Department with her mother that night?

88. While Dr Porter accepted that it was the decision of Masaly's mother to leave the Emergency Department, in his opinion Masaly's condition was not one that should have been left without further intervention and it was not appropriate for the department to end its responsibility to Masaly when she was taken from the department by her mother. Dr Porter asked the question, "do we lose the responsibility once they have left the hospital?"[149] If the answer is 'no' then Dr Porter suggested there needs to be a mechanism in place to follow up the child.

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[146] T 22 - 23; Exhibit 1, Tab 8, p. 5.
[147] T 22.
[148] T 92.
[149] T 15.

89. However, Dr Porter acknowledged that the failure of hospitals to follow-up such patients is not uncommon and is not limited to Broome Hospital.[150] Dr Porter acknowledged that even at Princess Margaret Hospital they have had poor systems in place in the past for following up children who are discharged by family without formal assessment and against medical advice, and are still struggling today with how to deal with patients who do not wait for assessment.[151] Dr Porter suggested in his report that, in light of Masaly's death, consideration should be given to the adequacy of the Emergency Department's procedures surrounding 'discharge against medical advice' and 'did not wait' events.

90. Dr Phillips gave evidence at the inquest that a direct outcome from Masaly's death was the creation of a 'did not wait policy'.[152] The WACHS Kimberley "Management and Review of 'Do Not Wait' Patients That Present to the Emergency Department Procedure" was introduced into Broome Hospital in November 2012. The procedure provides guidance around follow up of patients who do not wait to be seen in the Emergency Department. The procedures require that Emergency Department shift coordinators must review these cases immediately and bring them to the attention of the Emergency Department medical team leader for advice. If the patient requires follow up, the patient or next of kin is to be contacted to ask them to return to the Emergency Department for assessment. If appropriate, Aboriginal Liaison Officers can also be requested to follow up a patient. The procedure emphasises that special consideration should be given to paediatric patients, who are a high risk group, and it recommends practices that encourage a paediatric patient being seen quickly in the Emergency Department, to avoid parents taking the child from the waiting area without being medically assessed.[153]

91. Dr Phillips explained in her evidence that the policy is aimed at providing support to their vulnerable clientele, small babies being one of them. Other examples are the aged, the frail and the homeless. Dr Phillips accepted that it is very important that hospital staff do not discharge their responsibility to these

[150] Exhibit 1, Tab 8, p. 6.
[151] T 14, 25 – 26.
[152] T 90.
[153] Exhibit 1, Tab 5A.

vulnerable patients just because they have left the doors of the Emergency Department.[154] The way Dr Phillips described it, there is "accountability that has been put into the equation to make sure our patients, particularly our vulnerable ones, in our community are being looked after."[155] Dr Phillips indicated that they have not had a similar incident in Brome since these policies have been put in place.[156]

92. A number of other significant changes have occurred at the Broome Hospital Emergency Department since Masaly's death that are relevant to this inquest.

93. In 2011 Broome Hospital had two general practitioner District Medical Officers (DMO) working 8.00 am to 6.00 pm shifts, with an additional DMO on a 12.00 to 10.00 pm shift and 1 DMO on the night duty shift from 8.00 pm to 7.00 am. In addition there was a Resident Medical Officer (RMO) working shifts up to 40 hours a week. There was no paediatric service based at Broome Hospital at that time but paediatricians based at Derby Hospital would visit on a frequent basis.[157]

94. By contrast, in 2016 the medical resources have substantially increased although the overall proportion of Emergency Department presentations have not increased proportionately, so there are more doctors available to see people in the Emergency Department. The primary difference is an extra DMO working the 12.30 to 10.30 pm shift and there are now 6 full-time equivalent RMO's (rather than 1 RMO), allowing 1 or 2 RMO's on either a morning or evening shift 7 days per week.[158] Staff in other areas are also now rostered on, which avoids the need for Emergency Department staff to be called away to other areas of the hospital. Also, since July 2012 the paediatric service has moved to base itself at Broome Hospital, providing a consultative secondary role in managing children who present to the Emergency Department. There is always a Consultant Paediatrician on call within the hospital.[159]

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[154] T 91.
[155] T 91.
[156] T 91.
[157] T 81; Exhibit 1, Tab 5, Report [28].
[158] Exhibit 1, Tab 5, Report [28].
[159] T 81; Exhibit 1, Tab 5, Report [28] – [35].

95. Paediatric patients, such as Masaly, are also able to access a paediatric rapid review clinic that operates seven days per week, although the starting point is still an assessment by the Emergency Department District Medical Officer.[160] However, the WACHS Site Instruction for Broome Hospital[161] also indicates the paediatric team can provide that fast track service to children who have been identified as re-presenting to the Emergency Department where the workload of the Emergency Department DMO does not permit those children to be seen in a reasonable timeframe and where there is a risk that the parent may not wait for their child to be seen.[162] This would perhaps have averted what occurred in Masaly's case, at least on the third presentation.

96. Another important change is that Aboriginal Liaison Officers are now available to the department from 8.00 am to 11.00 pm 7 days per week.

97. Dr Phillips referred to the implementation of a much stronger culture emphasising patient safety with the introduction of the WACHS, "Clinical Escalation Including Code Blue – Medical Emergency Response Policy," dated 16 October 2014. This policy provides clear guidelines on matters that are required to be escalated to senior managers.

98. Also, following an internal review into Masaly's death, it was decided that Broome Hospital should develop a site instruction that addressed model of care and escalation responses for paediatrics.[163] In response the WACHS Kimberley implemented the Assessment and Early Management of the Unwell Child Procedure on 22 May 2014, which was an update on the previous procedure that dealt only with children 5 years and under who presented with a fever.[164] The procedure "prioritises and promotes the early identification of any unwell child who presents to any health site in the Kimberly and expedites the implementation of essential and appropriate treatment **without delay**, especially in the case of serious bacterial infection."[165]

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[160] Exhibit 1, Tab 5, Report [39].
[161] Broome Hospital Medical Model of Care, July 2015.
[162] Exhibit 1, Tab 5, Broome Hospital Medical Model of Care, July 2015, p. 4.
[163] Exhibit 1, Tab 5C.
[164] Exhibit 1, Tab 5D, p. 1.
[165] Exhibit 1, Tab 5D, p. 1.

99. The procedure acknowledges that Aboriginal children in northern and central Australia experience disproportionately high rates of disease from serious infection, particularly invasive pneumococcal disease, especially children under five years of age. An audit from 2005 to 2013 found children under five in the Kimberley had a mortality rate 7 times greater than the WA state average.[166] It is a deeply disturbing statistic. Masaly's death would have been one of these, and from invasive pneumococcal just as described. Given Masaly's case, the procedure appropriately points out that temperature alone is not a good predictor of serious bacterial infection. The procedures advocates the use of 'The Traffic Light Tool' to help identify where there is a risk of serious illness. It also mandates a comprehensive assessment, including dehydration and urinalysis, and emphasises that for babies under three months of age who are unwell, regardless of their presenting symptoms, should have a low threshold for admission and it encourages early consultation with more senior medical staff in such cases.[167] In keeping with Dr Porter's emphasis on the importance of the history, the procedure also emphasis caution where it is the second presentation with the same illness within 72 hours, there is parental/carer concern or there are significant social circumstances.[168]

100. Dr Phillips also gave some examples of changes to the Emergency Department that would ensure that the fact that a patient has re-presented would now be identified, unlike what occurred with Masaly in 2011. Dr Phillips explained that the triage form now prompts the triage nurse to ask for this information. The triage form prompts with the question "Re-presentation with similar or same symptoms within 48 hours."[169]. There is also a resource that is now dedicated to actually getting medical charts out quickly, so that the information can be checked.[170] Dr Phillips indicated that every medical record is now retrieved for every single patient.[171] This is clearly a significant improvement in terms of enabling Emergency Department Staff to get a clear understanding of the presenting history of a patient.

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[166] Exhibit 1, Tab 5D, p. 1.
[167] Exhibit 1, Tab 5D, p. 1 – 2.
[168] Exhibit 1, Tab 5D, Appendix 1 and Appendix 2.
[169] Exhibit 1, Tab 5F.
[170] T 87.
[171] T 95.

101. Dr Phillips described a change in the physical layout of the Broome Hospital Emergency Department, increasing the number of bays from four to twenty. Also, there is now an elevated 'flight deck' that allows staff to see everybody in the department, so every single patient who is acutely unwell is visible. That was not the case in 2011. The change in layout has a role to play in ensuring that people do not leave the Emergency Department without being seen leaving.[172]

102. There is also now more emphasis on the nurse coordinator as being the person who runs the Emergency Department and is accountable for the patient flow, preventing doctors from picking their own patients and perhaps causing some patients waiting longer than necessary. Dr Phillips described this role as very important as the person in that role is taking leadership of the patient flow.[173] It was apparent from Dr Phillips' evidence that she plays a pivotal role in the orientation of new doctors and medical students, and she has taken steps to ensure that new staff are oriented to the procedures in the Emergency Department and the particular cultural issues relevant to the Kimberley region, which might not be well understood by visiting staff.[174]

103. Dr Phillips was very confident that with the new procedures in place, a baby such as Masaly would not experience a two hour delay in being seen in normal circumstances.[175] Dr Phillips said in her evidence that "[t]hings are very different to how they were in those days,"[176] and on the basis of the evidence before me I accept that this is so.

104. It was acknowledged during the inquest that there is an impact on hospital staff, when a baby dies who they might have saved. Dr Phillips said in her evidence, "we like to think that we really care"[177] and described Masaly's death as "a tragedy." I accept that all of the hospital staff involved have felt that tragedy keenly and have actively taken steps to prevent a recurrence without waiting for the coronial inquiry to conclude.[178]

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[172] T 95.
[173] T 95 – 96.
[174] T 96.
[175] T 90.
[176] T 94.
[177] T 94.
[178] T 97.

105. As a result of the WACHS and Broome Hospital staff's active approach to implementing change to prevent another such death, I do not consider it necessary to make any recommendations for further change to be implemented. I am satisfied that the internal review processes have been sufficiently thorough and no counsel has raised any particular areas that might require further attention. I am reassured in that view by the fact that no further deaths have been reported of a similar kind in the six years since Masaly's death.[179]

CONCLUSION

106. When Masaly Mosby was taken to Broome Hospital Emergency Department in early October 2011, she had a number of features that marked her as a vulnerable patient. She was only just over a month old, she was an indigenous baby living in the Kimberley (and hence statistically more prone to infection and infant mortality) and she had been recorded as low birth weight at birth, although she was gaining weight appropriately. Her parents gave a history that she had been unwell, with fevers and vomiting.

107. On the first occasion Masaly presented to the hospital she was seen by a locum doctor who had not worked in the hospital previously but had experience treating small babies. He found Masaly showed no signs of infection and ultimately diagnosed her with a cold. He gave her parents some Panadol and sent her home, but told her parents to bring her back if they continued to be concerned or Masaly continued to have a fever or feeding difficulties. Although it might have been prudent to admit Masaly on this occasion, her care was reasonable given she showed no obvious signs of being unwell.

108. Masaly was brought back to the Emergency Department by family members twice more in the following days, but was not able to be assessed by a doctor as on both occasions she was taken from the hospital before a doctor was available to see her. Nevertheless, Masaly was seen by nursing staff on both occasions and she appeared to them to be reasonably well and they had no major concerns about her health that would suggest she required urgent medical attention.

[179] T 91

109. It is now clear that at the time Masaly was seen at Broome Hospital at least on 5 October 2011, if not earlier, she had a respiratory infection. After returning home with her parents that infection rapidly developed into a catastrophic bacterial infection that caused her death overnight on 5 and 6 October 2011 while she was sleeping with her parents. Her death is a tragedy.

110. Unfortunately, what Masaly's death has demonstrated is that small babies can often present as well but, when subject to infection, can then rapidly deteriorate and be in a critical state in a very short period of time. It is for this reason that paediatricians are particularly cautious to eliminate any possibility of infection when treating a very young baby who shows general signs of being unwell.

111. Since Masaly's death those involved in the management of Broome Hospital have taken steps to ensure that vulnerable babies are given appropriate and expeditious medical care if they present to the Emergency Department, and that there is less opportunity for them to be missed if they are taken from the department before medical review. I am satisfied that the steps taken demonstrate that lessons have been learnt from Masaly's tragic death.

S H Linton
Coroner
21 March 2017