Review into the quality of health services provided by Bamaga Hospital

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The Office of the Health Ombudsman acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and emerging.

Aboriginal and Torres Strait Islander peoples are advised that this report contains the name of a deceased person and refers to the death of a six-year-old Torres Strait Islander boy from Bamaga, Queensland. With permission from the family, we refer to him by his name.

Our office has tried to prepare the report in a respectful manner which acknowledges the concerns and actions taken by the parents in accessing healthcare for their son; and taking into consideration the customs and beliefs of the community, and while every effort has been made, the reader may find the content very distressing.

Review into the quality of health services provided by Bamaga Hospital, Queensland

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Foreword

This report presents the findings of an investigation into the safety and quality of health services at Bamaga Hospital, Queensland, following the death of Charles (Charlie) Izaak Wilfred Gowa. Charlie passed away on 14 January 2017, as a result of overwhelming sepsis caused by a rare bacterial infection called melioidosis, having been initially treated at the Bamaga Hospital.

I have decided to make this report public because I consider that there are lessons that warrant further dissemination, particularly in relation to the provision of health services in a remote environment.

I would like to thank Charlie's family for bringing his story to my attention, enabling my office to identify areas for system improvements. I would also like to thank staff from Torres and Cape Hospital and Health Service for their cooperation with the investigation and commitment to implementing the recommendations. Finally, I would like to thank the systemic investigations officers for their hard work and professionalism in conducting the investigation and preparing the report.

Andrew Brown
Health Ombudsman

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Executive Summary

Overview

Charles (Charlie) Izaak Wilfred Gowa passed away[1] on 14 January 2017 as a result of overwhelming sepsis caused by a rare bacterial infection called melioidosis.

Charlie was initially treated at Bamaga Hospital, located at the very northern tip of Queensland known as the Northern Peninsula Area (NPA). It also forms part of an endemic area where particular health issues like melioidosis are under the surveillance of the Queensland Health Tropical Public Health Service.

Charlie's mother has described significant issues with the standard of care provided to her son at Bamaga Hospital. Her concerns led to a complaint to this office regarding inadequate treatment provided to Charlie.

Among other things, the complaint raised two key issues in relation to the clinical management of Charlie, namely, it was alleged that:

- Charlie was taken to Bamaga Hospital Emergency Department (ED) by his parents on Thursday 5 January 2017 and every following day until he was finally admitted on Tuesday 10 January 2017. However, clinical records only commence on Monday 9 January 2017
- Charlie's condition was not appropriately considered, deterioration was not recognised, and his clinical care was not escalated accordingly.

This investigation concluded that, on the balance of probabilities:

- it was likely that Charlie did present to Bamaga Hospital prior to what is indicated in his medical records
- the treatment provided during earlier presentations (including rehydration ice block and paracetamol as attested by Charlie's parents) was likely inadequate and the failure to document any assessment on a febrile child brought in by concerned parents was not appropriate
- failure to document in medical records observations including symptoms and parental concern during earlier undocumented presentations meant that the practitioners that treated and discharged Charlie on 9 January, and ultimately admitted him on 10 January, did not have a complete picture of his condition
- these repeated presentations provided a potential trigger for further investigation that may have led to earlier intervention including earlier administration of appropriate antibiotics or referral for admission to a specialist paediatric unit.

[1] *Passed* and *passing* have been used in reference to Charlie's death and are used out of respect for his family.

Ultimately, this investigation does not find that the death of Charlie was preventable or that the actions of any individuals contributed to the tragic outcome. However, the systemic issues and necessary improvements discussed in this report do not rely on such a finding.

It should be noted that general deficiencies in documentation obstructed the ability of the clinical advisor appointed by the Office of the Health Ombudsman (the office) to provide a complete assessment of the care and treatment provided to Charlie at Bamaga Hospital including reaching any firm conclusions about decisions not to admit Charlie earlier than 10 January.

Bamaga Hospital belongs to the Torres and Cape Hospital and Health Service (TCHHS). Bamaga is a unique and very remote landscape, and is one of five Aboriginal and Torres Strait Islander communities that collectively form the NPA.[2] Accordingly, Bamaga Hospital consumers mostly identify as Aboriginal or Torres Strait Islander with Torres Creole being the predominant language spoken within the community.

Providing health services in Bamaga is challenging and not unlike other very remote areas that experience workforce shortages and difficulty obtaining the right skill mix. The remoteness of the service also poses its own resourcing and support structure challenges. There is also the added pressure of delivering culturally safe services to a culturally diverse population and meeting their health needs.

Charlie's passing was subject to two internal reviews by the TCHHS. The complaint and the health service's initial response to the office identified issues at Bamaga Hospital that were likely not isolated to this incident, potentially impacting other consumers who encounter the health service. Consequently, in July 2018 the office commenced a systemic investigation[3] into the quality of health services at Bamaga Hospital, TCHHS.

The office's systemic investigation primarily focused on the following key issues:

- clinical record keeping
- recognising deterioration
- communication and culture
- model of care
- inducting clinical staff and resourcing
- clinical governance
- clinical incident review
- open disclosure.

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[2] Injinoo, Umagico (Alau), New Mapoon, Seisa and Bamaga.

[3] Section 80(c) of the *Health Ombudsman Act 2013* (the Act) allows the Health Ombudsman to commence an investigation into another matter that the Health Ombudsman considers is relevant to achieving the objects of the Act, including public health and safety.

Clinical record keeping

Clinicians are required to maintain contemporaneous, thorough and accurate records of the care they provide to patients. Bamaga Hospital is required to support these important responsibilities through relevant record keeping policies, procedures and systems. In Queensland, all presentations, care and management plans should be documented in a patient's clinical record. However, this investigation identified multiple instances of incomplete or missing records relating to Charlie's care at Bamaga Hospital. These failings, if not adequately addressed, may pose a risk to patient safety. While Bamaga Hospital has taken steps to address record keeping issues at the facility since Charlie's passing, further measures are required to ensure high quality clinical records are kept for all emergency presentations.

Recognising deterioration

Bamaga Hospital is required to maintain and utilise mechanisms for recognising and responding to patient deterioration. In relation to Charlie's care, this investigation identified multiple instances of non-compliance with standard clinical tools, manuals and local policies and procedures designed to support clinicians in the recognition of, and response to, a deteriorating patient. The correct use of these tools is particularly important in remote settings like Bamaga, where the evacuation of a deteriorating patient to a suitably resourced facility takes time. Charlie's case highlights the need for Bamaga Hospital to ensure staff are trained in the application of these tools, with usage monitored and corrective action promptly undertaken when poor compliance is detected.

Communication and culture

Bamaga Hospital belongs to a Hospital and Health Service that is responsible for one of the largest Aboriginal and Torres Strait Islander populations in Australia. It is essential Bamaga Hospital implements high quality and culturally sensitive communication strategies and initiatives. This investigation identified multiple issues at Bamaga Hospital regarding the delivery of culturally appropriate care. Charlie's case highlights how such issues have the potential to negatively impact the quality of care provided to consumers. Since Charlie's case, a Consumer Liaison Officer based on Thursday Island has been recruited to provide a cultural liaison service at Bamaga Hospital and other surrounding communities. The existence of this new role is positive. However, this investigation identified ongoing issues with consumer access to patient escalation systems (Ryan's Rule) and practical language support. These issues require prompt attention and a sustained commitment to improvement.

Model of care

Bamaga Hospital houses one of only two emergency departments in the TCHHS catchment. Effective emergency department management is vital to ensuring presentations are appropriately triaged and addressed. In reviewing the policies, procedures, Charlie's clinical records, and other key information, the office was unable to identify a clear emergency model of care at Bamaga Hospital. Instead there appears to be a confused mix of services between the ED and the Primary Health Care Centre (PHCC), potentially resulting in poor triage practices and a failure to identify and manage emergency presentations. This office's view is that this issue presents a high risk to patient safety and must be addressed.

Resourcing and inducting clinical staff

Bamaga Hospital, like many remote health service facilities, will often face resource challenges. At the time of Charlie's care, there was a transient medical workforce in place and their placement period was short term. Despite Bamaga Hospital holding several clinical orientation documents, it was evident a thorough induction to the TCHHS was not provided to the locum practitioners that commenced their duties at the time, which may have impacted the continuity of care provided to Charlie. However, during the investigation permanent medical staffing arrangements were put in place. Although a positive improvement, the TCHHS needs to ensure a plan for instances where they need to rely on a locum workforce provides a level of orientation and induction that is effective and consistent.

Clinical governance

Bamaga Hospital requires robust clinical governance support from the TCHHS to ensure confidence in the systems in place, safe and high-quality healthcare is delivered, and there is drive to continuously improve its services. System processes such as clinical incidents and open disclosure require the TCHHS's attention. These processes were particularly flawed in response to Charlie's incident and require review and evaluation.

Clinical incident review

Bamaga Hospital needs to ensure it has a robust system and process that will support staff to appropriately identify, respond, report and review clinical incidents. It appears the TCHHS failed to support Bamaga Hospital to appropriately manage the circumstances surrounding Charlie's passing, lacking the necessary incident management governance framework to adequately identify, investigate and learn from clinical incidents.

Open disclosure

Bamaga Hospital failed to sensitively engage with Charlie's family in a timely, supportive and culturally appropriate manner impacting on the family's willingness to participate in an open disclosure process. The TCHHS requires a formalised policy and procedure that includes culturally appropriate responses following such incidents.

Adverse comment submission

Under the *Health Ombudsman Act 2013*, an entity must be given an opportunity to comment on a draft investigation report where that report is going to make adverse comment and the entity is identifiable.

The response from the Health Service Chief Executive, TCHHS dated 29 June 2020 is attached in full at **Appendix 4**. TCHHS has accepted all recommendations.

Two practitioners provided submissions during the adverse comment phase. Extracts of these submissions are captured in footnotes within relevant sections of the report. One practitioner declined to provide submissions.

Both practitioners who provided submissions during the adverse comment phase acknowledged the impact of Charlie's passing on his family and community.

Conclusion

Charlie's case is an example of the ongoing challenges and barriers the hospital and the community face. However, with the development and support of strong clinical governance and mutual partnerships in the area, the journey towards delivering a safe and quality health service can be achieved. The report makes a total of **20 recommendations** (see chapter 10).

1. Introduction

This report details the findings of investigations undertaken by the office into the quality and safety of health services in the context of the care provided to Charlie Gowa at Bamaga Hospital, Torres and Cape Hospital and Health Service (TCHHS) in early January 2017.

1.1 Background

On 3 May 2018, the office received a written complaint raising concerns about the care and treatment Charlie, a six-year-old Torres Strait Islander boy from Bamaga, in the Northern Peninsula Area (NPA), received at Bamaga Hospital between 6 and 10 January 2017, including:

- the hospital failed to correctly diagnose the cause of Charlie's symptoms in clinical record keeping
- Charlie's symptoms were incorrectly attributed to gastroenteritis for several days
- investigations were not performed, which delayed the diagnosis of melioidosis.

Charlie passed away on 14 January 2017 as a result of overwhelming sepsis caused by melioidosis.

The complaint and the information available appeared to identify broader issues considered to be of a systemic nature. Therefore, the office decided to undertake a systemic investigation to explore these issues.

1.2 Meaning of a systemic investigation

A systemic investigation focuses on issues that relate to the operation of a system, process or practice, as opposed to a person's individual actions that occur within the system.

The office classifies systemic issues into three streams based on population impact, namely:

Stream 1: These are issues that have the potential to impact persons at a single facility or within a single service line in a local area and can be resolved directly with the facility. These issues, while important, will have a minimal impact beyond a local community utilising the services of the facility or engaging with the service line.

Stream 2: These are issues that have the potential to impact persons across facilities within a single region or geographical location and can be resolved by engagement with a single key stakeholder responsible for the facilities. These issues, while serious, are likely to have less potential for widespread impact outside of the locality in which they occur.

Stream 3: These are issues that have the potential to impact persons across facilities throughout Queensland and require a coordinated response by multiple stakeholders to address any identified issues. The issues are likely to be the most complex, with the potential to have the greatest impacts or impact the largest number of persons.

In undertaking systemic investigations, the office can provide an independent viewpoint on the issues observed and coordinate with the key stakeholders to make recommendations to address issues, respond to trends and/or refine processes. Investigating systemic issues requires a more strategic and proactive approach, engaging with the stakeholder to effectively define and capture issues and securing their commitment to co-design and/or implement constructive recommendations for change that are appropriate and effective in their operating context.

The systemic investigation into the quality of health services provided to Charlie at Bamaga Hospital was classified as a **Stream 2** investigation.

1.3 Preamble to Charlie's story

Charlie's illness, rapid deterioration, and eventual passing was unexpected by his parents and family. His parents were left traumatised and his family developed serious concerns with the standard of care that was provided to Charlie at Bamaga Hospital. Although Charlie died in January 2017, their grievances have never been appropriately addressed by the facility or the TCHHS.

In 2020, Aboriginal and Torres Strait Islander peoples remain at a significant disadvantage compared to other Queenslanders across many health measures. At the heart of these inequities are people and their stories.

The purpose of including Charlie's story is to provide context to the complaint as received by this office and, importantly, to acknowledge the voice of his family in this process. It is the desire of Charlie's parents that by sharing their perspective, greater insight will be gained by TCHHS and improvements will be made to prevent such a story being told again.

This is the story of the care provided to Charlie Gowa, as told by his parents.

Part A: Charlie's story

2. Charlie's story

Charlie was born in Cairns but called the township of Bamaga in Far Northern Queensland his home. Its people are mainly Torres Strait Islanders who speak Creole, like Charlie, and it is a place where family and kinship groups still practise strong traditions.

Charlie lived with his mum and dad, and was the eldest of his siblings. Like many young six-year-old children in his town, Charlie was healthy and happy, spending his school holidays playing with his best friend, and was proud to be known as the tallest kid in his class.

Then one Thursday morning, Charlie woke up not feeling well. His parents could see he was not his usual self. Charlie's mother tried to give him some breakfast. Charlie did not want to eat at first but when he tried later, he vomited it all back up. He looked weak, had puffy eyes, had greenish black diarrhoea, and was running a high fever. Charlie tried to rest but would complain of a headache and cry with pain. Charlie even needed his mum and dad to help him to the toilet.

Charlie's parents were worried and decided to take him to the Bamaga Hospital later that morning.

His mum went with him to the hospital while his dad stayed home to look after his younger brother and sister. At the hospital, Charlie's mum said that Charlie was sick and had not slept well, that his body ached, and his diarrhoea did not look normal. The hospital told them a gastro bug was going around. Charlie was given an ice-block and Panadol, and told to come back to hospital if his sickness got worse.

That night, Charlie was still sick. He continued to vomit without even eating food and he told his mum it was hard to breathe. Charlie's mum watched him puff his chest right out and breathe really deeply like he could not get enough air in. Charlie's mum tried to hold him, comfort him, but he said his skin burned and he would get irritated if she placed her hand on him.

Around midday on Friday, Charlie's dad came home from work so Charlie and his mum could go back to the hospital. They waited for two hours before seeing someone. Charlie's mum again said he was still vomiting, had diarrhoea, was hot to the touch, had trouble breathing and was crying from his headache. Charlie was checked over but sent home with Panadol again, only to be told they could come back if he got worse. Charlie's mum felt a growing sense of worry for him. His dad was angry that the hospital would not do more. That evening, Charlie got worse.

On Saturday, and after another night of vomiting, diarrhoea and crying; Charlie's mum took him back to Bamaga Hospital in the morning. When she arrived with Charlie, she was told that there were no doctors working on weekends but if he got worse, one could be called in. She was told to come back with Charlie on Monday when a doctor would be at the hospital.

At home that day, Charlie's mum could see Charlie was not right. He looked into the distance as if he could see something that was not there. Charlie also began to wet the bed.

On Sunday, Charlie's mum carried her son back to the hospital. Again, she was told there was no doctor on over the weekend and to bring Charlie back the next day. Charlie's parents did not know what else they could do for their son but to keep taking him to hospital in the hope that someone would do something.

Charlie no longer had his energy and would just lie in bed, sick with painful headaches. He struggled to sit up and didn't want anyone near him.

On Monday, Charlie's dad stayed home so his mum could take him back to hospital that morning. After a long wait, a doctor came to see Charlie where he was given Panadol again and sent home.

When Charlie and his mum returned home that day, Charlie's dad became angry, *'Why won't they help him?'*

Charlie had barely kept any food down for four days. Everything he tried to eat, he threw back up. During that night, Charlie continued to cry, and his mum and dad took turns to carry him to the toilet.

On Tuesday, Charlie's dad took the day off work again so his mum could take him to hospital. Charlie's mum noticed Charlie could barely walk and that one side of his face seemed swollen and really puffy like he had been hit in the head and it had filled with fluid. Charlie's mum was finding it very upsetting to see her son like this. At the hospital, Charlie's mum told them they had tried to see a doctor over the weekend because he wasn't getting better. Charlie could not walk straight, his legs were shaking and he told his mum they hurt when he walked. At last Charlie was taken to a hospital bed where the doctor checked him over.

Charlie still had a fever so nurses placed cool towels around him. Later, the doctor told Charlie's mum they were going to keep him in. Charlie's mum was so relieved someone was finally doing something. Charlie's dad soon arrived at the hospital to stay by his side while his mum returned home to feed his younger brother and sister.

In hospital, they did tests on Charlie and brought his fever down. Exhausted, Charlie would sleep until his headache returned. Charlie would check that his dad was still by his side. Later that night, a doctor came to speak with Charlie's dad to tell him Charlie would need to be moved to Cairns Hospital. Charlie's dad asked the doctor what was happening but they said they were waiting on a call from the Flying Doctors. They weren't sure when, but they were making arrangements.

Wednesday morning came and Charlie needed to have a chest x-ray. Charlie was very quiet, barely speaking to anyone. Charlie's dad asked if his son could be taken to the x-ray in a wheelchair. Charlie was still having trouble walking. He had to lie down for his x-ray as he could hardly stand straight. Charlie's dad was also told there was a delay with the Flying Doctor Service as another patient needed to be transported from Thursday Island.

Charlie's mum came to visit him. The doctor told her they were not sure what was wrong with Charlie so he was going to Cairns to have more tests. Charlie's parents were later told he might have pneumonia. Charlie's mum became angry that Charlie had been so sick all this time and they did nothing to help him. When the ambulance arrived to take him and his dad to the airport for the flight to Cairns, Charlie's mum said goodbye to him and walked home to look after her other children.

It would be the last time she ever got to speak with her son, Charlie.

Charlie slept most of the flight. He didn't like to be touched, and grizzled when there was too much light in his eyes. During the flight, Charlie's blood pressure dropped and he was given extra fluid through the drip in his arm.

At Cairns Hospital, Charlie was taken straight to the emergency department but they could not find his chart from Bamaga Hospital. Cairns Hospital told Charlie's dad they would call Bamaga Hospital for it. Charlie was then transferred to the children's ward where his dad stayed by his side as they ran lots of tests on Charlie.

Charlie's dad was happy that Charlie was finally getting help but he could see his son was getting worse.

By now Charlie really hated being touched. He swore at the doctor who tried to examine him and Charlie's dad knew it was not like him to act this way and became very worried.

Early next morning Charlie's condition became much worse and he was moved to the Intensive Care Unit. A doctor came to speak with Charlie's dad. He said Charlie was very sick and they needed to put him into an induced coma. Charlie's dad was told they think he has melioidosis – a disease you can get from dirt and it makes you really sick. Charlie was put into a coma and attached to a machine to help him breathe.

Charlie's dad asked the doctor to tell him straight – *'how sick is my son?'* The doctor told him that Charlie was fighting for his life and that he may not make it. His heart was not strong enough to beat by itself. A specialist team had been called to Cairns to connect a machine to Charlie's heart and take him to Brisbane. They were arriving soon.

When the specialist team arrived, they took Charlie away to connect him to the machine to prepare for the flight to Brisbane. His dad waited and was later told he would not be able to fly on the same plane with Charlie. Charlie's mum, brother and sister were flown to Cairns but Charlie was already on his way to Brisbane with the specialist team. Charlie's parents flew down with the children on the next available flight to be with him in Brisbane and go straight to the hospital.

Before going in to see Charlie, his mum asked what her son looked like. Charlie's dad explained he looked different with all the machines connected to him and his body was bloated. Charlie was in intensive care while his family sat beside him all day.

The doctors later confirmed with the family that Charlie had melioidosis.

That evening Charlie's family went to their hospital accommodation to get some rest. They were overwhelmed by the large city, the busy hospital and how quickly their son was slipping away.

Early on Saturday morning, Charlie's dad received a call. They were needed back at the hospital.

Charlie's parents were told their son's brain was shutting down and it was very likely he would not survive. Charlie's family spent all day with him. After speaking with the doctor in the afternoon, they made the decision to stop his life support machines. They did not wish for their son to suffer any longer.

Arrangements were made for Charlie's extended family in Bamaga to be on the phone at this time and a prayer was said for Charlie in his final moments. Surrounded by his family, Charles William Izaak Wilfred Gowa passed away at 6:48 pm on Saturday 14 January 2017 in the Paediatric Intensive Care Unit of the Lady Cilento Children's Hospital in Brisbane, Queensland.

Charlie is deeply missed by the people that loved and cared for him. His family remain in constant connection to him and his memory. Charlie was buried at the Bamaga Cemetery with other members of his extended kin who have passed, with his grave adorned with some of his favourite toys.

Part B: Clinical picture

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3. Clinical picture

Two key issues in the clinical management of Charlie's case have been identified, namely, it is alleged that:

- Charlie was taken to Bamaga Hospital Emergency Department (ED) on Thursday 5 January 2017 and every following day until he was admitted on Tuesday 10 January 2017. However, clinical records only commence on Monday 9 January 2017
- Charlie's condition was not appropriately considered, deterioration was not recognised, and his clinical care was not escalated accordingly.

Each of these issues will be discussed below.

3.1 Multiple presentations

The clinical records obtained from Bamaga Hospital during this investigation do not match the information provided by Charlie's mother and father regarding the timeline of Charlie's care. Specifically, the sequence of events described by Charlie's parents indicate that he presented to Bamaga Hospital with his mother once a day, every day from Thursday 5 January 2017 until his eventual admission on Tuesday 10 January 2017. Conversely, clinical records provided by Bamaga Hospital indicate that Charlie's first presentation did not occur until Monday 9 January 2017.

This office took action to further explore the possibility of earlier undocumented presentations, after TCHHS had undertaken two internal reviews relating to Charlie's care without addressing the issue of the alleged multiple presentations to a satisfactory standard.

All presentations to a Queensland Health emergency facility require complete, accurate and contemporaneous clinical records. Record keeping requirements are also set out in relevant professional standards and codes of conduct for clinicians.

This investigation was unable to conclusively reconcile the events described by Charlie's parents with records provided by Bamaga Hospital. However, the evidence gathered by this office during this investigation identified three potential scenarios of his care in January 2017.

3.1.1 The three scenarios of multiple presentations

Scenario one: Charlie's parents' account

Charlie presented as described by his parents on five occasions commencing on Thursday 5 January 2017 until his admission on Tuesday 10 January 2017 and Bamaga Hospital staff failed to commence clinical recording until the Monday 9 January 2017 presentation.

Charlie's parents gave the Coroner's investigators this account on 7 July 2018. This sequence of presentations was also recounted to this office's investigators when they interviewed Charlie's parents on 29 August 2018. Charlie's parents said that Charlie was sent home with Panadol and instructions to return should his condition worsen. Charlie's parents report that he was acutely unwell at this time, with regular vomiting, diarrhoea and high temperatures.

Scenario two: Practitioner's account

Charlie presented from Saturday 7 January 2017 until his admission on Tuesday 10 January 2017.

This scenario partially overlaps with the narrative provided by Charlie's parents, and is based on a consultation note made by a practitioner who treated Charlie on Tuesday 10 January 2017 which states: 'presented to Bamaga Hospital last Saturday with 2 days V&D[4]'.

Scenario three: Clinical records and incident review account

Charlie's first presentation was on Monday 9 January 2017, one day prior to his admission on Tuesday 10 January 2017.

This scenario is strictly based on the records available and provided by Bamaga Hospital. It was also relied upon by TCHHS in their two clinical incident reviews into Charlie's care.

These three scenarios are shown in a timeline comparison in Figure 1.

[4] Vomiting and diarrhoea.

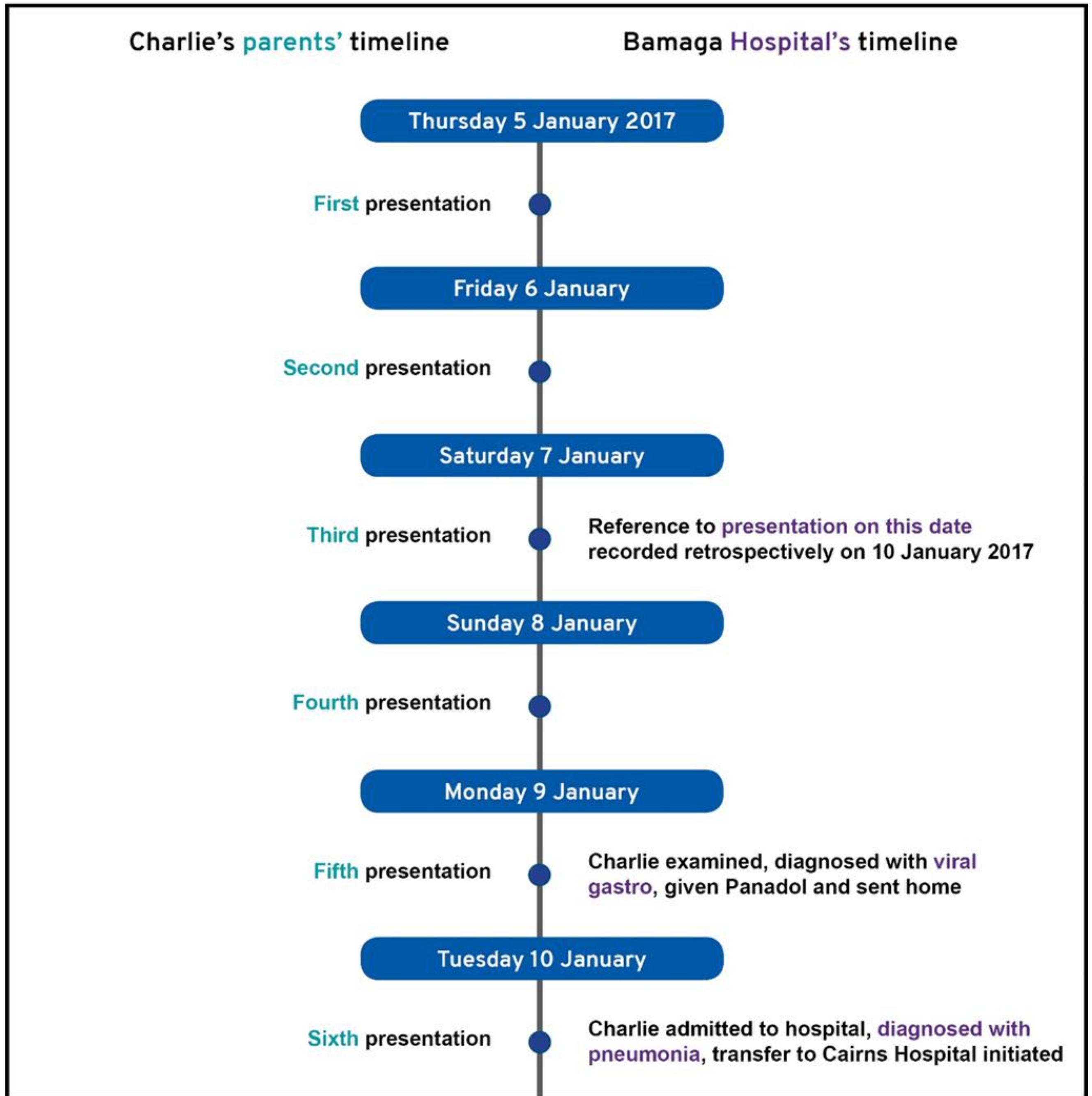

Figure 1 Timeline Comparison of Charlie's Presentations to Bamaga Hospital

3.1.2 Which scenario occurred?

Only scenario three is reflected in the documentation provided by Bamaga Hospital. Following consideration of the evidence gathered during the investigation, the weight of evidence supports the probability that undocumented presentations did in fact occur as described in scenarios one and two.

The evidence supporting this conclusion also forms part of the systemic issues identified in this investigation, and will be discussed in detail throughout this report.

The key indicators and other circumstantial elements alluding to Charlie's undocumented early presentations occurring in some form are as follows:

3.1.2.1 Concerns raised by Charlie's mother

The first recorded occasion in which Charlie's mother raises concerns that she presented with Charlie on a date prior to the documented period is Tuesday 10 January 2017. These concerns were both recorded in Charlie's clinical notes and corroborated during this investigation by the practitioner who treated Charlie that Tuesday.

In submissions to the office, the practitioner recalled feeling confused and somewhat frustrated with what Charlie's mother was reporting, being that she had presented with Charlie on the previous Saturday 7 January 2017, and the absence of any corresponding clinical record. The practitioner further recalls that Charlie's mother was unhappy that Charlie had previously been seen but was still unwell.

This information is significant. It confirms that the first recorded instance of Charlie's mother raising concerns about early and subsequently undocumented presentations occurs before she could have possibly been aware of the trajectory of Charlie's condition, and before any complaint or investigation was afoot. It suggests the story as told by Charlie's parents is credible, and was first raised at the time of Charlie's care in January 2017.

3.1.2.2 Record keeping at Bamaga Hospital

This investigation identified significant record keeping issues in relation to Charlie's care at Bamaga Hospital. Even among Charlie's documented presentations, records were identified as non-compliant with requirements, incomplete or missing entirely. These observations were consistent with information provided by a medical officer who had worked at Bamaga Hospital during January 2017. They described the facility's records, such as patient triage notes, as at times brief, and not particularly informative.

Furthermore, information obtained from another medical officer who worked at Bamaga Hospital during the same period indicated that an undocumented presentation to the facility similar to Charlie's story was a possible scenario. This was also based on their observations and concerns with, at times, an overall laxity towards record keeping by clinical staff.

A poor record keeping culture at Bamaga Hospital may have contributed to an environment in which Charlie's undocumented presentations in some form are a clear possibility. Poor clinical record keeping and its impact on Charlie's care is discussed in detail in section 9.1.1.

3.1.2.3 Staff recollection and changeover of Locum Medical Officers

During this investigation, information was obtained from various clinical staff who were working at Bamaga Hospital in January 2017. This included staff who were rostered on during the time of Charlie's alleged undocumented presentations (5 January to 8 January 2017, inclusive).

In providing information, many of the practitioners contacted during this investigation indicated that their recollection of Charlie's care, or that period, was compromised due to the significant time elapsed since the event. No practitioner contacted during this investigation could categorically confirm or discount that Charlie presented to Bamaga Hospital prior to what is documented in his clinical record.

Issues with establishing a consistent and accurate timeline of events was further compounded by the changeover of Locum Medical Officers (LMOs) that occurred at Bamaga Hospital at the time of Charlie's care. New LMOs commenced working at the facility on Monday 9 January 2017, replacing the LMOs from the week prior.

As a result, none of the LMOs working at the Bamaga Hospital in January 2017 were able to provide information on what was occurring at the facility across the entire time period in question (Thursday 5 January 2017 to Wednesday 11 January 2017).

The absence of a clear account from clinical staff is not direct evidence of Charlie's undocumented presentations having occurred. However, it is a significant issue when considered in comparison to the detailed narrative provided by his parents.

3.1.2.4 Bamaga Hospital emergency department (ED) model

Information obtained from practitioners previously employed at Bamaga Hospital describe the facility as a disorganised and at times chaotic environment with many patients presenting to the ED seeking care more appropriately suited to the community Primary Health Care Centres (PHCC).

This investigation identified that the Bamaga Hospital ED routinely manages patients not requiring emergency treatment. Such a model carries risk and may create an environment in which important ED protocols are at times poorly complied with.

The way in which the Bamaga Hospital ED functioned and the disordered environment described by individuals who worked there underpins many of the issues that likely contributed to Charlie's early presentations being undocumented. This is discussed in detail in section 9.2.2.1.

Conclusion

This office is of the view that it is more probable than not that Charlie did present to Bamaga Hospital prior to what is indicated in his medical records. However, the systemic issues and necessary improvements discussed in this report do not rely on this issue being wholly substantiated.

3.2 Clinical management of Charlie's care

The full chronology of Charlie's clinical care is outlined in Appendix 1.

3.2.1 Melioidosis in children

Melioidosis is a complex infection caused by the bacteria called Burkholderia pseudomallei found mostly in the soil of endemic areas like South East Asia and tropical Australia. Most cases notified in Queensland are in the state's north, in particular the northwest Gulf country, the Torres Strait Islands, and Townsville and nearby environs.

Aboriginal and Torres Strait Islander peoples are disproportionately affected by melioidosis. The average melioidosis notification rate for Aboriginal and Torres Strait Islander Queenslanders is 14.3 times higher than for non-Indigenous Queenslanders.[5] Furthermore, Torres Strait communities in Northern Queensland have historically recorded higher annual rates of melioidosis infections compared to other Australian regions.[6] Melioidosis is relatively uncommon even among people in endemic areas who have close contact with soil or water containing the infectious agent. In approximately two-thirds of cases, the patient has another medical condition that makes them susceptible to infection, e.g. poorly controlled diabetes, chronic renal failure, or excessive alcohol consumption.

Paediatric melioidosis is uncommon in Northern Australia. However, a 2017 study[7] identified that children in Far North Queensland who contract melioidosis have a higher rate of mortality even when they receive optimal care. Melioidosis is difficult to diagnose in children as they are often asymptomatic, making reliance on standardised tools exceptionally important when managing their care.

3.2.1.1 Impacts of disease and health alerts

Melioidosis can present in several different ways, including:

- infection of the lungs, which can range from mild bronchitis to severe pneumonia
- septicaemic pneumonia (infection throughout the bloodstream, as well as the lungs)
- disseminated melioidosis, which spreads from the skin through the blood to become a chronic form of melioidosis affecting the heart, brain, liver, kidneys, joints, and eyes
- localised infections.

Symptoms usually develop within three weeks of a person being exposed to the bacteria, but in some cases, illness may not occur until several months or years after the initial infection.

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[5] Queensland Health: *Melioidosis in Queensland*, https://www.health.qld.gov.au/__data/assets/pdf_file/0026/671183/melioidosis-qld-2012-2016.pdf

[6] The Department of Health: *Melioidosis in northern Australia, 2001-02*, https://www1.health.gov.au/internet/main/publishing.nsf/Content/cda-pubs-cdi-2003-cdi2702-htm-cdi2702n.htm

[7] Report, *Children with melioidosis in Far North Queensland are commonly bacteraemic and have a high case fatality rate*, Smith et al 2017, https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdi4104-e

Diagnosing melioidosis can take upwards of three days requiring growing the bacteria via testing of blood, sputum, urine or a swab from an abscess or non-healing ulcer. Generally, patients will be treated for other presenting symptoms such as sepsis and while melioidosis is the cause of the illness, quick treatment is required to prevent significant deterioration and possible death.

On 16 January 2017, following Charlie's passing, the Director of Tropical Public Health Services (TPHS) in Cairns issued a media statement to TCHHS, Cairns and Hinterland Hospital and Health Service (CHHHS), local schools, council, and non-government organisations, advising of an increase in melioidosis cases that year. This was followed by the circulation of the *Melioidosis Fact Sheet* from Queensland Health.

Melioidosis was present in the Torres and Cape region with eight cases of melioidosis in the region being reported between 1 January 2017 and 31 March 2017.[8]

3.2.2 Sepsis in children

Due to the prolonged episode of melioidosis without treatment, Charlie developed sepsis.

Sepsis is a rare but life-threatening illness caused by an abnormal response of the body to an infection. It can lead to tissue damage, multiple organ failure and death. It can be caused by any infection (viral, fungal, bacterial), but most commonly occurs with bacterial infections of the lungs, urinary tract (bladder, urethra, kidneys), abdomen, skin and soft tissues.[9]

Anyone can develop sepsis. However, children, infants, people of Aboriginal and Torres Strait Islander descent, and those with a weak immune system are most at risk.[10]

Both professionals and the public can find it extremely difficult to recognise sepsis during the early stages of the illness as its symptoms (e.g. confusion, fever, rapid heart rate, and breathing difficulties) are commonly suggestive of less serious illnesses. An estimated 18,000 Australian adults are treated in intensive care units for sepsis annually, of which almost 5,000 die. Of those who survive, half are left with a permanent disability or impaired function.[11]

In paediatric patients, sepsis represents the leading cause of death and disability in children, with mortality rates higher than road toll deaths and leukaemia. One-third of children who survive sepsis will suffer long-term disability such as loss of limb/s and neurocognitive impairment.[12]

Sepsis is a medical emergency that requires early identification and treatment.

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[8] Tropical Public Health Services (Cairns) Newsletter, *TROPICAL PUBLIC health news*, Issue 7, June 2017, https://www.health.qld.gov.au/__data/assets/pdf_file/0036/659916/tphs_newsletter_june-172.pdf
[9] Queensland Health: Clinical Excellence Queensland, *Sepsis in children*, http://conditions.health.qld.gov.au/HealthCondition/condition/8/120/826/sepsis-in-children
[10] ibid
[11] Queensland Health: Clinical Excellence Queensland, *What is sepsis?*, www.clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/resist-sepsis-program/what-sepsis
[12] ibid

3.2.3 Clinical opinion on Charlie’s condition

In March 2019, investigators obtained an independent clinical opinion with a view to gaining a better understanding of sepsis and melioidosis and the impact on Charlie’s condition. The independent clinical advisor, who specialises in paediatric infectious diseases, reviewed all evidence relevant to Charlie’s presentations at Bamaga Hospital.

The clinical advisor made multiple references to the limited and inadequate documentation in Charlie’s Bamaga Hospital clinical records. He commented, in relation to the lack of records prior to 9 January 2017, that it was ‘…*dangerous and not in the patient’s best interest*’.

The complete lack of documentation for 5, 6, 7 and 8 January 2017 was described by the clinical advisor as significant if Charlie did present to Bamaga Hospital on those days and indicative of a ‘*substantial deficit in the quality of care’*. It was further explained that Charlie’s repeat presentations, in addition to the collection of symptoms, and parental concern resulting in repeated presentations would all warrant further investigations and may have led to earlier administration of appropriate antibiotics and an earlier referral for admission to a specialist paediatric unit. On this point it is noted that a practitioner involved in Charlie’s care on 9 January 2017 submitted that they did not know about any of Charlie’s earlier presentations and *‘..would certainly have considered it relevant information..’* had they been made aware of it.

The advisor considered the treatment (including a rehydration ice block and paracetamol on 5 January 2017, and paracetamol on 6 January 2017, as attested by Charlie’s parents) was likely inadequate and the failure to perform any assessment on a febrile child brought in by a concerned parent on 7 and 8 January 2017 (weekend presentations) was not appropriate.

It was also recognised by the advisor that in the context of the early undocumented presentations, the hospital may have failed to respond to Charlie’s mother’s level of concern, which impacted on Charlie’s illness and his access to appropriate treatment and management.

The documentation issues will be discussed in more detail later in this report. However, it was noted to have obstructed the clinical advisor’s ability to provide a complete assessment of the care and treatment provided to Charlie at Bamaga Hospital.

Charlie's clinical records on 9 January 2017 document findings of lethargy and weakness as well as persistent high fever several days into his illness, with the absence of clear evidence of significant dehydration[13]. The clinical advisor's opinion was that this combination of clinical findings raises the possibility of complications of gastroenteritis or an alternative diagnosis, including an invasive bacterial infection.[14] It is also of note that mandatory clinical tools purposed for the early recognition of clinical deterioration were not used on this date. Notwithstanding this, the clinician acknowledged that viral gastroenteritis is the most common cause of presentation of fever and diarrhoea in children.

The clinical advisor was of the opinion that the care and treatment provided to Charlie on 10 and 11 January 2017 could be improved but was appropriate overall. This was demonstrated by Charlie's admission into hospital, the advice sought from the paediatric registrar in Cairns Hospital, activating retrieval, and commencing empiric antibiotics and fluid resuscitation.

It was noted by the clinical advisor that Charlie's retrieval delay from Bamaga Hospital to Cairns Hospital on 10 and 11 January 2017 as a result of logistical reasons was '*unfortunate*' and may have delayed access to further investigations which would have assisted in the diagnosis of severe sepsis and melioidosis. Also, while Charlie's clinical records show evidence of severe sepsis in Bamaga, the clinical advisor reported that melioidosis as a cause of sepsis in children is very rare and would not be considered by most clinicians as the likely cause of Charlie's presentation.

The clinical advisor also noted that a venous blood gas (VBG) was not performed and would have provided useful information on the severity of Charlie's condition on 10 January 2017. A practitioner involved in Charlie's care submitted:

> *'I agree that VBG would have been beneficial. However, there were no CG4+ cartridges available at Bamaga Hospital on 10 January which meant that I was unable to perform that test. If there had been cartridges available I would have arranged for VBG to be tested after Charles' admission together with the other tests I arranged, which included blood cultures. In addition, had there been point of care testing available for a white cell count and differential, and a C Reactive Protein, as is available in other rural hospitals, I would have ordered these as well.'*

Aside from the submissions from this practitioner, this investigation did not identify any information relating to the availability of CG4+ cartridges at the time of Charlie's care, including within Charlie's clinical record or the two clinical incident reviews undertaken by TCHHS as discussed in section 9.3.2 of this report. These submissions are the first occasion such information was brought to the attention of this office. If these submissions are accurate, the management of point of care stock is another important patient safety measure that may require careful attention from Bamaga Hospital.

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[13] '*out of proportion to the volume of diarrhoea'*

[14] A practitioner involved with Charlie's care on 9 January 2017 has submitted in response to the draft investigation report that *'it is [their] usual practice to exclude the possibility of serious bacterial infection in any child presenting with a febrile illness (i.e. fever). Despite Charlie presenting with a fever on 9 January 2017, [the practitioner's] examination of him (pulse, respiratory, oxygen saturation, respiratory effort, and peripheral perfusion) did not suggest that Charlie was toxic or seriously unwell. [The practitioner] also considered the possibility of the most common bacterial causes for fever (acute otitis media, tonsillitis, pneumonia, cellulitis, appendicitis, meningitis) but found there to be no clinical signs of those diagnoses'.* **Comment:** the clinical records confirm the practitioner's initial examination at 1441 hours. The clinical advisor was provided with the practitioner's submission, but maintains the original advice regarding the possibility of complications of gastroenteritis or an alternative diagnosis, including an invasive bacterial infection.

Charlie’s weight and urine output were not measured and given the concerns of gastroenteritis, and presumably dehydration, normal practice would include serial measurements of weight and careful recording of fluid balance.[15]

The clinical advisor also identified the following deficiencies with Charlie’s clinical management:

- The initial Children’s Early Warning Tool (CEWT)[16] assessment and BGL result of 8.2 should have prompted an immediate review by a medical officer and commencement of a BGL monitoring form. Monitoring BGL would have been particularly important given Charlie was administered significant volumes of fluid which did not contain dextrose.[17]
- Contact with the Cairns Paediatric Registrar for advice occurred 2 hours and 20 minutes after his presentation on 10 January 2017, and this was the time that the decision was made to give antibiotics. In cases of bacterial sepsis, the first dose of antibiotics should be given within the first hour. The total delay of 4 hours and 50 minutes from the time of presentation is inappropriate by this measure.
- Charlie displayed further signs and symptoms indicating multifocal disease (pneumonia, left knee arthritis, severe pain in other locations). Consideration should probably have been given to a diagnosis of invasive, multifocal Staphylococcus aureus disease (most likely pathogen based on local epidemiology), and antibiotic cover of intravenous vancomycin could have been commenced. However, it was reported that this would not have treated melioidosis and would not have impacted on the ultimate outcome for Charlie.

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[15] A practitioner involved in Charlie’s care on 10 January 2017 further submits that ‘*It is important to note that, at the time of Charlie’s presentation on 10 January 2017, he was eating and drinking normally and did not have vomiting or diarrhoea during his admission. In any event, Charles’ weight was recorded at 19.1 kilograms on admission and this is documented in the records. Ordinarily we would not check a child’s weight more than once a day. Charles’ fluid balance was monitored overnight (although not formally as he passed urine into the toilet rather than in being measured). His urine was tested on multiple occasions. …These results indicated appropriate urine output for his age and weight and his hydration status appeared to be satisfactory*’. **Comment:** The practitioner’s clinical records note that Charlie was eating and drinking normally with normal urine output. The clinical advisor was provided with the practitioner’s submission, but maintains the original advice regarding serial measurements of weight and careful recording of fluid balance.

[16] CEWT: Observational chart for early recognition of clinical deterioration in children followed by prompt and effective action to minimise the occurrence of adverse events

[17] A practitioner involved in Charlie’s care on 10 January 2017 submits *‘Charles had a finger prick blood sugar test on ED presentation (8.2). His blood sugar was checked subsequently on venous blood and was within normal range’*.
Comment: As per the clinical advice obtained during this investigation, monitoring of Charlie’s BGL was not commenced on this date as mandated in the CEWT. A blood glucose level can be obtained readily at the bedside without any delay. Clinical records indicate that on 10 January 2017, Charlie’s BGL was checked at 2:00pm (on presentation) and once more at 11:36pm that evening. It is acknowledged that the later result was within normal range; however, this does demonstrate a potential systemic issue with the failure to commence a BGL monitoring form.

It was considered by the clinical advisor that the clinical findings on both 10 and 11 January 2017 of severe, multifocal pain and arthritis of at least the left knee suggested an invasive disseminated bacterial infection as do the chest x-ray findings from the morning of 11 January 2017. Bacterial sepsis would later be further supported by the high CRP and low white cell count on blood tests from 10 January 2017. However, these results were not available until after Charlie was transferred to Cairns Hospital.

The clinical advisor reported that:

> *'... severe sepsis is defined by sepsis with cardiovascular dysfunction or organ dysfunction affecting at least two other systems. Septic shock is defined by severe sepsis with cardiovascular dysfunction that is refractory to fluid resuscitation. Based on these definitions, Charlie's clinical records indicate evidence of severe sepsis at 4.30am on 11 January 2017, given the presence of hypotension in addition to meeting SIRS criteria. He later developed fluid-refractory septic shock while admitted at Cairns Hospital.'*

Sepsis is a time critical disease and there was a delay in administering antibiotics with no reference of sepsis in any of the clinical records between Bamaga Hospital, Retrieval Services Queensland (RSQ), and the Royal Flying Doctor Service (RFDS).

Excluding from consideration the absence of any records available regarding any presentation for 5 January 2017 to 8 January 2017 inclusive, and the difficulty in assessing the appropriateness of the decision to discharge Charlie on 9 January 2017, the clinical advisor did not identify evidence of treatment by a medical practitioner that is out of keeping with *Good Medical Practice: a code of conduct for doctors in Australia.*[18]

Having regard to the opinions expressed by the clinical advisor regarding Charlie's clinical management and care, and the issues concerning the quality of his clinical records, including his possible multiple undocumented presentations, the investigation of potential systemic issues is justified in the circumstances.

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[18] *Good Medical Practice*, Medical Board of Australia, March 2014, www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

Part C: Systemic issues at Bamaga Hospital

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Listen. Respond. Resolve.

4. Systemic issues at Bamaga Hospital

This section of the report will address in detail the systemic issues identified during the investigation. As previously referenced, this systemic investigation was categorised as a Stream 2 matter, as the issues have the potential to impact persons across facilities within a single region or geographical location and can be resolved by engagement with a single key stakeholder responsible for the facilities.

It is important to note that this report does not seek to blame individuals for failings in the care provided to Charlie, but rather to identify deficiencies in the systems and processes which they were performing their duties within.

5. Investigation scope

After collating the information obtained during this investigation, the following issues were identified and analysed in detail:

- clinical record keeping
- recognising deterioration
- communication and culture
- model of care
- inducting clinical staff and resourcing
- clinical governance
- clinical incident review
- open disclosure.

6. Inquiries by the office

6.1 Investigative inquiries

During this investigation, information was obtained via submissions, documents and interviews. The information determined the issues identified and supported the investigation's scope. A complete list of these documents can be found in Appendix 2 on the office's website.

In addition to the documentary analysis, staff from the office also:

- engaged with the Northern Coroner, who supplied the initial 7 July 2018 statements provided by Charlie's parents
- attended a meeting with the Director of Tropical Public Health on 28 August 2018
- met with the complainant and Gowa family in Bamaga on 29 August 2018
- attended a stakeholder meeting at Bamaga Hospital on 30 August 2018
- obtained independent clinical advice from a paediatric infectious diseases specialist on 11 March 2019 and 7 June 2020.

7. National and state frameworks and guidelines

There are several national and state standards, frameworks and guidelines that apply and influence the safety and quality of health services provided by Bamaga Hospital. A list and brief overview of those referenced within this report can be found in Appendix 3.

8. Health service background

8.1 Torres and Cape Hospital and Health Service

On 1 July 2014, the Cape York Hospital and Health Service and Torres Strait–Northern Peninsula Hospital and Health Service merged to form the TCHHS, becoming one of Australia's largest providers of health services to Aboriginal and Torres Strait Islander peoples.

The TCHHS provides health services to the most northern part of Queensland including a chain of islands from the top of mainland Cape York to within three kilometres of Papua New Guinea. This equates to approximately 26,500 people, with 64 per cent identifying as Aboriginal or Torres Strait Islander, who rely on the services of the TCHHS. It is managed from four regional hubs: Cooktown and Weipa (southern), Cairns and Thursday Island (northern).[19]

The TCHHS comprises 31 PHCCs, a Multipurpose Health Service (MPHS) in Cooktown, an Integrated Health Service (IHS) in Weipa, and the two main hospitals located in Bamaga, in the NPA and Thursday Island, the administrative centre of the Torres Strait (see Figure 2).

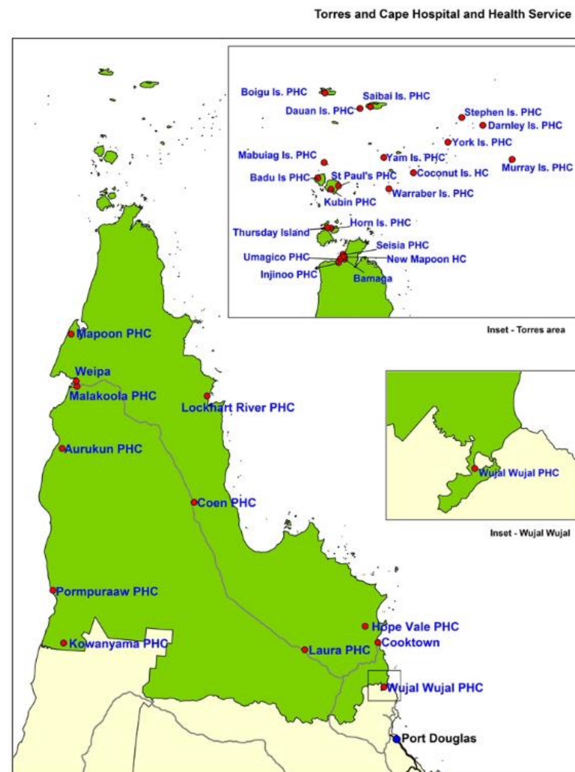

Figure 2 Torres and Cape Hospital and Health Service

[19] TCHHS, *Annual Report 2017-18*, https://www.publications.qld.gov.au/dataset/torres-cape-hhs-annual-reports/resource/e574717b-50cf-46db-86a1-1a1e59e9b99b

8.2 Bamaga Hospital

As prefaced, Bamaga Hospital is located in the NPA region. The NPA region is home to five Aboriginal and Torres Strait Islander communities on the lands of the Injinoo people, who are the traditional owners. Bamaga's population is approximately 75 per cent Torres Strait Islander and 20 per cent Aboriginal. The main language spoken is Torres Strait Creole, although English and Kala Kawa Ya are also spoken.

It is a unique landscape and its remoteness and cultural diversity is an additional challenge in an already demanding workplace. Health issues known to the region include acute rheumatic fever (ARF), poststreptococcal glomerulonephritis, melioidosis, diabetes, and sexually transmitted diseases/infections.[20]

Bamaga Hospital's services include an ED, ambulatory care, mental health, an Alcohol, Tobacco and Other Drugs Service (ATODS), and a satellite renal service. It consists of 10 inpatient and two emergency beds, servicing a population of 2,900 people of predominantly Aboriginal and Torres Strait Islander heritage. There is also a General Practitioner (GP) practice co-located in the hospital which has been reported to be transitioning to the Bamaga PHCC since 2016. At the time of this report it is unknown whether the transition has since been completed.

8.2.1 Bamaga Hospital Emergency Department

Under the Clinical Services Capability Framework (CSCF),[21] Bamaga Hospital is categorised as a level 2 service, or community hospital.[22] As a level 2 service Bamaga Hospital:

- operates a 24/7 ED with access to a registered nurse to triage all presentations and a registered medical practitioner available on-site within 30 minutes at all times (in normal circumstances)
- provides treatment for minor injuries and illnesses and limited treatment of acute illnesses and injuries
- provides basic resuscitation and limited stabilisation, including short-term assisted ventilation prior to transfer to a high-level service
- is supported by services including allied health professionals as required, pharmacist (or approved registered nurse), patient support staff and security personnel.

For higher-level care (including significant trauma, cardiac events and serious medical conditions), Bamaga Hospital has facilities to assist with the stabilisation of the patient while they are awaiting transfer to the nearest appropriate facility such as Thursday Island, Cairns or Townsville hospitals. These transfers are facilitated by the responsible medical officer and coordinated by RSQ and the RFDS. The significant distance from Bamaga to other referral hospitals in the state, in addition to a three-month wet season, can impede access to services due to its 'very remote' location.[23]

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[20] Queensland Health, *Tropical public health services*, https://www.health.qld.gov.au/cairns_hinterland/html/gp-tph-alerts
[21] Department of Health, *Emergency services,* CSCF, v3.2, https://www.health.qld.gov.au/__data/assets/pdf_file/0027/444276/cscf-emergency.pdf
[22] Queensland Health, *Community hospitals*, https://www.health.qld.gov.au/clinical-practice/engagement/networks/rural-remote/rural-facilities/community-hospitals
[23] Queensland Health, *Rural and remote areas*, https://www.health.qld.gov.au/mass/subsidy-schemes/rural-remote

An example of the impact that the very remote location has on transferring patients is that a Priority 1[24] transfer that should usually take 30 minutes will take two to three hours from Bamaga. This may be the result of certain flight requirements, due to weather and/or runway conditions.

Bamaga Hospital reported that most patients who present to the ED are triaged as a category 4 or 5,[25] meaning that they are generally non-urgent conditions that could more appropriately be managed by the GP practice at the Bamaga PHCC. This has been an ongoing issue for Bamaga Hospital and is discussed in section 9.2.2.1. All patients who present after hours regardless of triage category, are treated at Bamaga Hospital ED.

8.2.2 Bamaga Primary Health Care Centre

In the NPA there are five Indigenous communities that each have their own PHCC including Bamaga, New Mapoon, Seisia, Injinoo, and Umagico. The PHCCs continue to work within the Torres model of care that was launched in 1996 to address the poor and worsening health of the area's Indigenous people. It was designed to be culturally sensitive and aimed to promote collaboration between health professionals, Indigenous health workers, and consumers[26] of the region.

The Bamaga PHCC provides access to a GP, general outpatients, palliative support, outreach specialist services, and allied health services. Telehealth services are also available for linking with other facilities and services via teleconference for patients. It operates Monday to Friday between 8 am and 5 pm via appointment or walk-in presentations.

Any acute presentations to the PHCCs are referred to Bamaga Hospital.

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[24] Royal Flying Doctor Service, *Priority system*, https://www.flyingdoctor.org.au/wa/clinical/aeromedical-retrieval/organising-flight/priority-system/
[25] Refer to section 9.2.2.1 of the report for triage categories.
[26] Consumer includes patients, clients, residents, families, carers and communities.

9. Issues

The scope of the investigation considered several issues that impacted the overall care and management Charlie received at Bamaga Hospital as well as the subsequent actions undertaken by the TCHHS in response to the incident.

9.1 Managing clinical risk

9.1.1 Clinical record keeping

Contemporaneous and complete clinical record keeping is an essential component of providing safe care. The NSQHS Standards[27] reinforce this position by stating that undocumented or poorly documented information can result in misdiagnosis and harm. It is a well-established and standard expectation of both individual clinicians (through their various codes of conduct) and hospitals that all presentations, care and management plans should be documented in the clinical record, whether paper or electronic. This should have occurred every time that Charlie presented to Bamaga Hospital and interacted with a clinician. However, as further discussed below, this did not always occur.

9.1.1.1 Bamaga Hospital electronic systems and procedures

At the time of Charlie's care in 2017, patient clinical records at Bamaga Hospital were paper-based, and supported by other enterprise electronic patient information systems to capture patient data including:

- Emergency Department Information System (EDIS) which '…follows the progression of a patient through the emergency department. The system is able to monitor patient progress and provide alerts, and record treatment details'.[28]
- Hospital Based Corporate Information System (HBCIS) which is 'Queensland Health's enterprise patient administration system, capturing and managing both admitted and non-admitted patient, clinical, administrative and financial data'.[29]
- *Patient Information Management System Best Practice (Best Practice)* utilised by clinical staff in both the hospital setting and the PHCCs to capture patient presentations and access clinical information across TCHHS.
- The Viewer, which is a web-based application accessible by hospital staff that displays key patient information such as pathology results, radiology results, medications, allergies and alerts, care plans, as well as discharge summaries from health services across Queensland.

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[27] Australian Commission on Safety and Quality in Health Care, *Documentation of information*, https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/documentation-information
[28] Queensland Health, *Business planning framework: a tool for nursing and midwifery workload management, Emergency Department Addendum 2018* https://www.health.qld.gov.au/__data/assets/pdf_file/0029/715538/bpf-addendum-ed.pdf
[29] ibid

The TCHHS Clinical Record Documentation procedure is aimed at ensuring compliance with, and use of, the above record keeping systems. This procedure is informed by the requirements of the NSQHS Standards and Queensland Health policies. The procedure sets out a variety of clinical record keeping requirements covering:

- admissions
- progress notes
- clinical pathways and forms
- consent
- medication
- adverse events.

9.1.1.2 Best Practice

Best Practice is used by the clinicians at Bamaga Hospital to manage:

- patient overflow from the PHCC GP service
- admissions to the hospital
- transfers of a patient to another facility.

Other staff have access to a patient's *Best Practice* clinical record to view patient history, medication lists and other relevant information. Bamaga Hospital acknowledged that *Best Practice* is essential to assist in servicing a transient population who move between the NPA, Thursday Island and Torres Strait Islands. Unfortunately, the system can be unstable. Accordingly, the *Best Practice* Software Downtime procedure outlines the processes for when there are *Best Practice* system outages. Outages can occur because of the remoteness of Bamaga Hospital's location and stability of the network. A clinician involved with Charlie's care reported to this office that there was an outage on 9 January 2017, impacting on the completeness of Charlie's clinical record. The procedure requires clinicians to use 'downtime forms' until the system is restored. Once access is restored then it is expected that all data from the 'downtime forms' will be entered or scanned into the appropriate clinical records by all *Best Practice* users.

The impact that poor clinical documentation can have on a patient's care, such as Charlie's, reinforces the importance of clinicians and/or hospital administration staff ensuring that data needing to be entered after a system outage is done so in a timely manner. This will support patient safety and improve clinical communication and management.

Best Practice system outages are likely inevitable given Bamaga's remoteness. TCHHS has accounted for this inevitability through its procedure. However, the lack of compliance with clinical record keeping requirements when the records are paper-based is indicative of a broader system issue in relation to staff compliance with record keeping policies and procedures and suggests a culture where record keeping is not made a priority.

9.1.1.3 *Charlie's clinical records*

Consistent with the NSQHS Standards, it is mandatory for any presentation to a TCHHS facility to be documented within the patient's clinical record. The entry must include (at a minimum) the date, time, reason for presentation and all clinical actions taken. This should be captured in any relevant electronic system and on the patient's hardcopy clinical file. This is the responsibility of all Bamaga Hospital staff. However, during the investigation it became evident that this type of documenting does not routinely occur.

Based on the information provided by Bamaga Hospital during this investigation, other than the outage on 9 January 2017, all electronic clinical record keeping systems and paper clinical records were operational at the facility on 5, 6, 7 and 8 January 2017. However, as is stated above, there are no clinical records of any of Charlie's earlier presentations. Further, Charlie's records provided by TCHHS during this investigation for his 9 January 2017 presentation are incomplete, including what follow-up actions were taken in response to the recorded management plan.[30]

As is also stated above, Charlie's parents' account is that Charlie was taken to Bamaga Hospital on 5, 6, 7 and 8 January 2017. Charlie's parents said that Charlie was sent home with Panadol and instructions to return should his condition worsen. Charlie's parents reported that he was acutely unwell at this time, with regular vomiting, diarrhoea and high temperatures.

The only documented reference to these presentations relates to 7 January 2017, and appears in a clinician's consultation notes on 10 January 2017, stating, he 'presented to Bamaga Hospital last Saturday with 2 days V&D'.

As outlined in section 3.1, Monday 9 January 2017 was Charlie's first documented presentation at Bamaga Hospital. Charlie's clinical records for this date contain an ED triage form, consultation notes by an LMO, and a medication record. During this investigation, the LMO who treated Charlie that day indicated that within the documentation provided by Bamaga Hospital regarding Charlie's care, urine analysis results, fluid challenge results and follow-up observations were missing. Further, interviews with practitioners during this investigation identified that *Best Practice* had 'crashed' that Monday, which impacted on the recording and saving of electronic records.

When Bamaga Hospital received notification of Charlie's passing on 16 January 2017, Charlie's treating LMO from Monday 9 January 2017 realised consultation notes were missing from Charlie's electronic file and uploaded a retrospective record. This record notes the *Best Practice* outage on that Monday and referred to a hardcopy consultation note added to Charlie's clinical record. The retrospective electronic record was uploaded following a conversation between the LMO and the Medical Superintendent of

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[30] The practitioner who treated Charlie on 9 January 2017 submitted that *'… following observation, Charlie's temperature had dropped and his vital signs remained within the acceptable range….Charlie was cooperative, relaxed, appeared hydrated and was smiling. Accordingly, [the practitioner] discharged Charlie. That discharge occurred following consultation with, and agreement from, Charlie's mother, who was advised by [the practitioner] to immediately return to Bamaga Hospital should Charlie either deteriorate or fail to improve…'.*
Comment: Aside from submissions from this practitioner, this investigation was unable to corroborate information regarding Charlie's discharge on 9 January 2017, as records of these purported repeat observations, the decision to discharge and consultation with Charlie's mother are not contained within the clinical records provided by TCHHS to this office.

Bamaga Hospital during a debrief regarding Charlie's case. It was during this time that the Superintendent advised the LMO that inclusion of retrospective notes were acceptable provided it was clear within the clinical record that they were retrospective, with all the correct times and dates, content and signatures being recorded.

While these consultation notes were identified as missing and retrospectively uploaded to Charlie's electronic file, the other missing records[31] for the Monday presentation were not included. This missing material has never been located and no explanation for the absence of these records in Charlie's file could be established during this investigation.

When Charlie returned on 10 January 2017, the medical officer was unable to locate any information about the earlier presentations and had to verbally confirm the 9 January 2017 presentation due to the incomplete clinical record at that time.

Throughout the course of Charlie's care on 10 January 2017, document maintenance was deficient, evidenced by an incomplete CEWT, no documentation concerning Charlie's deteriorating condition (despite transfer arrangements being made and his condition likely suggesting a necessary change to his urgent retrieval status) and no recorded change in diagnosis or record of a differential diagnoses.[32]

Additionally, there were no records to indicate what information had been communicated to Charlie's family including whether there were discussions about his condition, treatment plan, retrieval and transfer plans and associated delays, or any offer of cultural support.[33]

On Wednesday 11 January 2017 when Charlie was transferred to Cairns Hospital, the RFDS records were the main source of information for Cairns because the records from Bamaga Hospital did not enable any continuity of care or provide detailed information about the management of Charlie's condition to that point.

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[31] Urine analysis results, fluid challenge results and observations

[32] A practitioner involved in Charlie's care on 10 January 2017 submits *'On 10 January 2017 I caught an early flight (7am) to Bamaga from Cairns. I was on call and it was busy. I did not finish at Bamaga Hospital until, to the best of my recollection, about 10pm that night. I then had calls throughout the night, attended at 0130 hours, and was back at 0800 hours. We had two very sick patients on the evening of 10 January 2017, in a rural and remote hospital with very limited support on site. Whilst not an excuse, I feel these factors did impact on the standard of my record keeping.'*

[33] The same practitioner as referred to in the footnote above, submits *'I recognised Charles was very sick, stated this to his mother, and I submit that the steps I took reflected my level of concern for his condition … Charles' parents were very attentive and caring parents. I believe I listened to Charles' parents, communicated my concerns and the uncertainty regarding the diagnosis to them, explained to them the proposed medical management and sought and obtained their consent, and kept them updated regarding treatment and the consultations I had with Retrieval Services and Paediatrics at Cairns Base Hospital. I acknowledge that this should have been more clearly documented in the medical records; particularly when Charles' retrieval was deferred from that evening to the next morning.'*

Comment: Aside from submissions from this practitioner, this investigation was unable to corroborate information regarding consultation with Charlie's parent's on 10 and 11 January 2017 as there are no details of such discussions contained within the clinical records provided by TCHHS to this office.

It was clear to investigators, when interviewing clinicians involved with Charlie's care, that the lack of documentation (both the missing presentations and incomplete information) impacted on communication between the clinicians, hospitals, and retrieval services, and Charlie's ongoing management when transferred to Cairns Hospital.

9.1.1.4 Bamaga's current approach to clinical record keeping

As a result of the issues with Charlie's care, subsequent passing and the office's involvement, Bamaga Hospital has reported the following steps to improve clinical record keeping compliance, including:

- reminding staff of their obligation to maintain clinical records in line with the TCHHS procedure. Bamaga Hospital provided an email sent to staff by the Director of Nursing/Facility Manager on 6 December 2017
- reminding staff that early warning tools are to be used for all patient presentations. Bamaga Hospital provided an email sent to staff by the Nurse Unit Manager on 5 January 2018
- using the chart tracking list[34] to ensure the chart location is up to date and evidence of presentations and/or access to a patient file is recorded
- reviewing the process flows for 'non-urgent planned emergency department representations' and requesting feedback from staff
- updating checklists for clinical record requirements for both paediatric and adult admissions
- reminding staff that the PCCM is to be followed when documenting patient information.

It is positive that Bamaga Hospital has identified and taken some steps to address issues with its clinical record keeping practices. However, the above measures do not ensure compliance. It is critical that the facility continues to monitor performance in relation to relevant NSQHS record keeping standards, and that any identified issues of non-compliance are promptly addressed.

Irrespective of his uncertain first presentation date, Charlie's clinical record was incomplete. While it is not possible to quantify the impact this ultimately had on his care and management of his presenting condition, it is an issue of significant concern.

While submissions have been received from individual clinicians in relation to compliance with record keeping requirements, representatives of Bamaga Hospital and TCHHS have not been able to provide a reasonable explanation for the laxity of the record keeping evidenced by this case. The measures taken since Charlie's passing to address these issues are insufficient. Charlie's records, both paper and electronic, did not comply with the TCHHS's documentation procedure or the NSQHS Standards.

It is necessary for Bamaga Hospital to mitigate its risk of poor and/or serious outcomes arising from poor clinical record keeping. It is recommended that measures to facilitate compliance with record keeping policies and procedures are introduced as a priority.

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[34] Chart tracking list: a paper-based table document kept in the administration area of the Bamaga Hospital

9.1.2 Recognising deterioration

When caring for a patient, clinicians are required to use prescribed standard documents and tools that assist them to identify whether a patient's condition is deteriorating. These documents contain triggers for escalating a patient's care when certain indicators are met. Bamaga Hospital is responsible for ensuring that its clinicians understand their obligations in maintaining these records and respond to deterioration appropriately.

These requirements are supported through the NSQHS Standards, which set out expectations for small rural and remote facilities in recognising and responding to deterioration. The Recognising and Responding to Acute Deterioration Standard specifically references the importance of locally tailored protocols for recognising and responding to deterioration in rural and remote settings.

To meet its requirements under the NSQHS Standards, Bamaga Hospital uses the following documents and tools to aid clinicians in understanding their obligations in recognising and responding to deterioration:

- Rural and Remote Emergency CEWT
- PCCM
- local policies and procedures.

The above tools provide a framework for clinicians to undertake their duties within, and are designed to reduce potential bias in, clinical decision making and increase patient safety. Further, with correct use of these tools, practitioners are provided a platform with which they are able to initiate escalation and any required transfer arrangements should a patient under their care show signs of deterioration.

This investigation identified the following:

- parental concern was not recognised by Bamaga Hospital during Charlie's presentations
- as indicated in the independent clinical advice, relevant tools were not appropriately utilised, which may have impeded recognition of Charlie's deteriorating condition and escalation of his care
- Bamaga Hospital was unable to provide sufficient evidence to indicate regular monitoring is undertaken of compliance with the use of clinical tools or appropriate remedial action occurs to ensure full compliance when issues are identified.

The gaps in Charlie's care were significant, and highlight Bamaga Hospital's need to ensure their clinical staff remain educated and trained in the use of all tools and follow the processes indicated in the TCHHS procedure and PCCM.

9.1.2.1 Recognising parental concern

Charlie's parents reported that when Charlie woke feeling very unwell on the morning of Thursday 5 January 2017, they had a level of concern that prompted them to seek medical care for Charlie at their local hospital. Charlie's parents assert that over the next five days, Charlie and his mother returned to Bamaga Hospital where they were advised gastroenteritis was prevalent in the community at that time, and was the likely cause of Charlie's illness.

Irrespective of the exact number of Charlie's undocumented presentations, his mother's level of concern was not recorded in the existing documentation and appears not to have been recognised by Bamaga Hospital.[35] This lack of recognition raises the question of whether it contributed to the length of time the seriousness of Charlie's illness was undetected. A parent's perspective and level of concern about their child is an important consideration when assessing the child's condition. Parental concern forms part of the new paediatric sepsis pathway (discussed in section 9.1.2.5) as it is understood that parents are well versed in their child's usual presentation. High parental concern is an indicator suggesting further action may need to be taken by clinicians to investigate an unwell child.[36]

Charlie's mother placed a level of trust in the hospital; she appears to have followed their instructions, and in what is known to be consistent with Torres Strait Islander culture, she did not question or escalate her concerns even with a growing sense of frustration that she shared with Charlie's father each time she returned home with their son. Charlie's parents were also not aware of Ryan's Rule, an escalation tool that was available to them and an issue discussed further in this report (see section 9.2.1.1).

Additionally, Bamaga Hospital staff should have considered the Primary Clinical Care Manual (PCCM) to assist in recognising parental concern and used the Children's Early Warning Tool (CEWT) to assess any deterioration upon Charlie's presentation to the ED. Both of these issues are discussed in more detail below.

Since Charlie's passing, parental concern has become a high-level inclusive risk factor in recognising paediatric sepsis. It also appears in the TCHHS Procedure for Sepsis – early recognition and management, effective since 9 August 2017.

Below are examples of factsheets for parents and clinicians developed and implemented by Queensland Health in December 2018 (see figures 3 and 4). These resources did not exist at the time of Charlie's care. However, they are particularly pertinent in the context of his clinical symptoms and story as told by his family. They highlight how Charlie's symptoms and the high level of concern his parents had for his condition were typical and time-critical signs of sepsis in a child.

One component of the Paediatric Sepsis Symptoms poster designed for clinicians even uses an example of a mother holding a child speaking the words:

'They said it was gastro – I am worried it's something worse' (see Figure 3).

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[35] Submissions from a practitioner involved in Charlie's care are referenced above.

[36] Submissions from a practitioner involved in Charlie's care on 9 January 2017 states that they '... *liaised with Charlie's mother throughout the presentation on 9 January 2017 … discussed Charlie's treatment and eventual discharge with Charlie's mother and at no time observed her to be exhibiting concern that Charlie should not be discharged or was being treated inappropriately'.*

Comment: Aside from submissions from this practitioner, this investigation was unable to corroborate information regarding consultation with Charlie's mother on 9 January 2017 as there are no details of such discussions contained within the clinical records provided by TCHHS to this office. Further, this practitioner was unaware of the previous presentations and of any potential concern expressed on those occasions.

Figure 3 Paediatric Sepsis Symptoms Poster for Clinical Areas, Sepsis Resources, Clinical Excellence Queensland, published December 2018[37]

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[37] Queensland Health, Clinical Excellence Division, *Could this be sepsis?*, https://clinicalexcellence.qld.gov.au/sites/default/files/2018-12/poster-paediatric-clinicians.pdf

Queensland Health

Could this be sepsis?

Sepsis is a medical emergency and needs immediate treatment.

It happens when the body is fighting an infection but it starts to attack itself. Sepsis can damage the heart, blood vessels, lungs, kidneys and blood clotting systems, and can even cause death. The best chance of getting better from sepsis is to treat it quickly.

Knowing if your child has sepsis is tricky because many of the symptoms are like those we see in common infections which will get better with simple treatment and care.

Sepsis is rare but we all need to know what to look for.

You know your child best and we need you in our team.

Trust your gut feeling

If you feel your child is more unwell than ever before or this illness is different from other times - just ask your doctor or nurse "Could this be sepsis?"

Knowing the signs of sepsis

Any ONE of these may mean your child is critically unwell. Come to hospital straight away - DON'T DELAY.

Other signs and symptoms of serious illness in children who may have sepsis:

Any infection can cause sepsis. Most infections in children are caused by viruses and they will get better in a few days with care at home. Some infections need treatment with antibiotics to get better. The list below has some of the signs and symptoms in children who are sick. These may also mean a child is sick with sepsis.

If you think your child is not getting better, or they are getting sicker, **trust your gut feeling**. Tick the boxes of the signs and symptoms your child has, and ask your doctor or nurse **"Could this be sepsis?"**.

Temperature

- ☐ Shivering or shaking with a fever
- ☐ Low temperature (less than 36°C)
- ☐ High temperature (more than 38°C) for 5 days or more
- ☐ High temperature (more than 38°C) in a baby 3 months or younger

Breathing

- ☐ Grunting noises when breathing
- ☐ Working harder to breathe – sucking under the ribs or caving in of the breast bone
- ☐ Nostrils that move in and out (flare) with each breath
- ☐ Crackly noises from the chest

Activity and movement

- ☐ Can't concentrate
- ☐ Can't stay awake
- ☐ No interest in playing
- ☐ Not interested in what is happening around them
- ☐ Irritable and won't settle
- ☐ Restlessness
- ☐ Unable to walk or refusing to walk
- ☐ Not using an arm, leg, hand or foot for no obvious reason
- ☐ Feeling more unwell than they have before

Pain

- ☐ Headache, neck, muscle, chest, bone or joint pain for no obvious reason
- ☐ Pain relief is not working

Skin

- ☐ Cold hands and feet
- ☐ Skin painful to touch
- ☐ Bright red skin all over
- ☐ Rash

Toileting

- ☐ No urine (wee) or wet nappies for 12 hours or more
- ☐ Fewer nappies and not as heavy as usual
- ☐ Blood in the faeces (poo)
- ☐ More than 5 watery diarrhoea (poo) episodes in 24 hours

Eating and drinking

- ☐ Unable to keep any fluids down because of vomiting
- ☐ Vomit that is green or black or has blood in it
- ☐ Not interested in drinking or feeding
- ☐ Very thirsty
- ☐ Dry mouth, lips and tongue

We know that illnesses can change. Trust your gut feeling. Even if your child has recently been seen by a doctor, if you think your child may have sepsis come back to the hospital and just ask

"Could this be sepsis?"

Figure 4: Paediatric Symptoms for Parents, Sepsis Resources, Clinical Excellence Queensland, published December 2018[38]

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[38] Queensland Health, Clinical Excellence Division, *Could this be sepsis?*, https://clinicalexcellence.qld.gov.au/sites/default/files/2018-12/factsheet-parents.pdf

9.1.2.2 Cognitive bias in clinical decision making

Cognitive bias can lead a clinician to decide upon a patient's condition without adequate consideration of other possible diagnoses.[39] In Charlie's case there was a 9 January 2017 note in his clinical records that there was 'gastro in community currently'.

Submissions obtained from the LMO who treated Charlie on 9 January 2017 indicated that information about the presence of gastroenteritis in the Bamaga community was provided by the triaging nurse that day. In other submissions to the office, the triaging nurse stated that during December 2016 and early January 2017, there was a 'protracted epidemic of gastroenteritis mostly in the paediatric population presently [sic] to the Bamaga Hospital' and that the 'Public Health team were involved from the beginning'. The triaging nurse indicated that during the outbreak, the hospital dispensed an oral rehydration solution to affected patients.

This investigation was unable to independently verify that there was a gastroenteritis 'epidemic' in the Bamaga community during the period of Charlie's case. Enquiries made with the QH Tropical Public Health Unit indicated they held no records of a gastroenteritis outbreak in the Bamaga region at the time of Charlie's care.

The investigation did not find that cognitive bias played a role in Charlie's case. However, its potential to impact on treatment is worth reflecting on in this context. Further, it is noted that issues were identified with the use of debiasing clinical tools at the facility such as the CEWT.

9.1.2.3 Children's Early Warning Tool

The CEWT was introduced in 2007 and seeks to provide clinicians with a standardised set of observations for managing a child's presenting condition and quickly recognising deterioration. The CEWT was developed to assist bedside staff to identify patients who may be deteriorating or critically unwell, at an early stage, and initiate timely intervention, as failure to recognise and respond to clinical deterioration within a certain timeframe can lead to unexpected death or permanent harm.

The CEWT is a visual observation plot chart that comes in four age categories, each with a corresponding set of standard observation values and triggers relevant to the child's age bracket. There is also a CEWT designed for rural and remote locations with defined actions that correspond with the setting and clinical capability where the care is being provided.

An age appropriate rural and remote CEWT should be utilised for all unplanned and planned paediatric presentations and admissions across TCHHS. The CEWT should be commenced as soon as possible upon the child presenting. Routine observations and actions taken in accordance with the CEWT are defined in the form and are primarily the responsibility of nursing staff. When using the CEWT, clinical staff are required to add up scores that correspond to various vital signs and generate an overall score.

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[39] Sullivan et al, 'Cognitive bias in clinical medicine', *Journal of the Royal College of Physicians of Edinburgh*, September 2018, https://pubmed.ncbi.nlm.nih.gov/30191910/

In general, the higher the score the higher the intervention required. Urgent intervention can be in response to an overall high score or a single high score in one vital observation.

As indicated in the independent clinical advice obtained during this investigation, Charlie should have had a CEWT completed on his presentation to Bamaga Hospital on 9 January 2017. However, there is no evidence in the clinical records that suggests a CEWT was ever commenced on this date.

The first use of the CEWT occurred on 10 January 2017, when Charlie was admitted. In reviewing the CEWT completed for Charlie's care on this date, this office's investigation identified the following concerns (many of which were not addressed during TCHHS's incident review, as discussed in section 9.3.2):

- a CEWT was not commenced until two hours after Charlie presented to the facility
- the initial CEWT form used was an 'Emergency Department Tertiary and Secondary Facility' form instead of the correct 'Rural and Remote Emergency' CEWT
- at 4.30 pm, a CEWT score of five should have prompted a medical review within 30 minutes, but there is no documented evidence indicating this ever occurred
- at 5 pm, CEWT observations were undertaken but no total score was recorded and the primary survey was incomplete
- multiple total scores on the CEWT forms were incorrectly calculated or altogether absent. It is a requirement of the tool to total and record all scores, including a '0' if applicable
- observations were either not conducted or not recorded at the frequency required by the CEWT
- numbers were written in the vital sign chart plot area instead of the recommended dot, causing visual noise that can affect a clinician's ability to detect deterioration[40]
- other peripheral information was missing throughout the form including intervention codes, intervention clinical comments, operator initials and other initial assessment information.

The CEWT's completion was not in accordance with best practice, nor did it comply with the TCHHS procedure for Early Warning Tools (EWT) used in recognising and responding to clinical deterioration, which requires all staff to comply and document a patient's baseline observations within 30 minutes of their presentation. Mandatory training is also provided to all clinical staff to ensure compliance with use of the CEWT. Given these requirements, all staff should have been sufficiently aware of how to complete the CEWT and the expectations on them in ensuring it was completed when providing clinical care.

These failings, observed by the investigators, may be considered minor in nature when in isolation. However, when combined they have the potential to undermine a clinician's ability to detect and appropriately escalate a patient's deteriorating condition. For example, use of the incorrect CEWT could have affected the escalation pathways that were followed in relation to Charlie's CEWT scores. This is because some of the escalation pathways for a tertiary or secondary facility are different to those for a

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[40] Christofidis, MJ, Hill, A, Horswill, MS, Watson, MO, 2015. 'Observation chart design features affect the detection of patient deterioration: a systematic experimental evaluation', *Journal of Advanced Nursing*, 72(1), 158-172, https://pubmed.ncbi.nlm.nih.gov/26556775/

rural and remote facility, particularly where escalation includes coordination of retrieval to a higher-level facility.

Various clinicians interviewed during this investigation indicated that it was not uncommon for key clinical tools to be missed at Bamaga Hospital, including the CEWT. This was also reflected in the poor results from the 2017 Queensland Bedside Audit (QBA)[41] that was undertaken after Charlie's passing.

To monitor compliance with the procedure and obligations in relation to the CEWT, TCHHS participates in the QBA. Although only one child patient was available for sample at Bamaga Hospital at the time of the 2017 audit, results identified that a complete set of observations was not recorded within their applicable CEWT chart. In response to the audit results, Bamaga Hospital advised it implemented a specific corrective action plan which included enforced compliance with the CEWT, random patient chart checks and increased CEWT education initiatives. The office requested Bamaga Hospital provide evidence to demonstrate its corrective actions and/or ongoing non-compliance management strategies. To date, the office has not received this evidence. It is necessary to determine these initiatives' efficacy and whether additional improvement is required to ensure Bamaga Hospital clinicians are accountable for correct CEWT use.

Statements made by clinical staff to investigators about poor clinical documentation generally, and the deficiencies identified in Charlie's care, highlight the need to improve the compliance culture at Bamaga Hospital. While the hospital undertakes mandatory education and training, and a portfolio specific to each NSQHS Standard is assigned to a nominated nurse, little evidence was produced during this investigation that indicated regular review, monitoring and evaluation of the CEWT is undertaken at the facility. In the absence of compliance evidence, Bamaga Hospital should consider additional approaches to achieve compliance with the use of recognising and responding to deterioration clinical tools.

9.1.2.4 Primary Clinical Care Manual

In addition to TCHHS policies and procedures governing the use of standardised tools, Bamaga Hospital also utilises the Primary Clinical Care Manual (PCCM), which is the principal clinical reference document used by clinicians to guide their provision of care in rural and remote locations. The PCCM contains clinical guidelines and health management protocols. Specifically, section 8 of the PCCM relates to the best practice standards for paediatric care in rural and remote heath care settings. The history and physical examination component of section 8 sets out recommended actions for managing a child's care, including:

- use of the CEWT in rural and remote settings for unscheduled presentations
- paying careful attention to the history from the parent or carer
- ensuring that the child and parent feels that they have done the right thing in bringing the child to the facility regardless of the concerns

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[41] QBA: A major clinical patient safety audit undertaken within Queensland Health annually. The audit is aligned with the NSQHS Standards and other safety and quality indicators undertaken by public hospitals and health services during a specified period.

- when a child presents to a facility, the clinician is required to obtain information to identify the patient's health status and perform standard clinical observations, including recording vital signs.[42]

Coupled with the issues identified with Bamaga Hospital's CEWT compliance, there was also non-compliance with the PCCM. Specifically, the PCCM recommends that a parent's level of concern be considered in conjunction with the CEWT. However, as outlined in section 9.1.2.1, there is no record of Charlie's parent's concerns in any of his clinical documentation.

Improvements in this regard are necessary to ensure safe healthcare in rural and remote facilities such as Bamaga Hospital, particularly for paediatric presentations.

9.1.2.5 Sepsis Pathway

At the time of Charlie's care, a specific sepsis tool was not available to the clinicians to aid them in recognising Charlie's deterioration and prompting them to consider a diagnosis of sepsis.

Increased rates of sepsis in Queensland have made its management a priority for Queensland Health. The Clinical Excellence Division, Queensland Health, advised the office that in August 2017 the inaugural Paediatric Sepsis Forum was held in Brisbane. Following on from the forum, the Statewide Paediatric Sepsis Working Group (the group) was formed and has focused on developing a paediatric sepsis clinical pathway, which includes a sepsis screening and recognition tool, treatment bundle, and antibiotic prescribing and administration guidelines. The pathway aims to support emergency department clinicians to provide standardised, time-critical care to paediatric patients with sepsis.[43] Currently, there are 42 sites on trial and expansion is planned to all sites in Queensland.

In addition to the pathway, the group has developed a supporting education package for clinicians including lectures, case-based discussions, skill stations, quizzes and an eLearning package with SToRK.[44] The group is supporting education for rural and remote areas via RSQ.

Queensland Health has also launched a new sepsis program, RESIST: Recognise Early Signs Initiate Sepsis Treatment. The initiative specifies that early recognition, escalation and treatment will increase the likelihood of improved patient outcomes (including reduced mortality). Some measures of program success will include an increase in the percentage of patients with a sepsis diagnosis:

- who were recognised within three hours of presentation
- whose care is escalated to a senior physician within one hour of recognition
- who receive intravenous antibiotics within one hour of recognition

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[42] Queensland Government, *Primary Clinical Care Manual*, 10th Edition 2019, https://www.publications.qld.gov.au/dataset/primary-clinical-care-manual-10th-edition/resource/daa18ed4-7edf-4c0d-bb3a-2030d634f20c

[43] Queensland Health: Clinical Excellence Division, *Paediatric sepsis*, https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/resist-sepsis-program/paediatric-sepsis

[44] The Simulation Training on Resuscitation for Kids (SToRK) program provides online, face-to-face and in-service training packages for clinicians across Queensland on paediatric emergency, basic and advanced life support.

- who commenced on a sepsis pathway within four hours of presentation.[45]

In August 2017, TCHHS introduced the Sepsis – Early Recognition and Management procedure, which describes the processes for prompt and effective treatment of sepsis, including fluid resuscitation and commencement of appropriate intravenous antibiotics within 60 minutes (and preferably within 30 minutes) from the time of sepsis recognition or diagnosis.

Bamaga Hospital advised that on 13 September 2017, they commenced implementing the sepsis pathways for adults and children. Specifically, there are new TCHHS Adult and Paediatric Sepsis Flowcharts and Protocols on trial that have been circulated to Bamaga Hospital staff. If compliance with this pathway is not ensured, its aims will not be met, increasing the likelihood of a case like Charlie's reoccurring.

Figure 5 compares the 2019 emergency standard for managing sepsis in children (within the first 60 minutes) and Charlie's care at Bamaga Hospital.

[45] Queensland Health, Clinical Excellence Division, *What is sepsis?*, https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/resist-sepsis-program/what-sepsis

Sepsis emergency management in children — *First 60 Minutes*		Charlie's care at Bamaga Hospital
0 minutes	Fever greater than 38.5°C or hypothermia, sick or toxic appearance, irritable or drowsy, poor perfusion, rash, altered mental state, increased work of breathing, marked or persistent increased heart rate, moderate to severe dehydration and seizures	Charlie's complete set of vital signs not promptly obtained, recorded or appropriately monitored on any presentation
	Close attention to vital signs and risk factors including Torres Strait Islander descent	
First 5 minutes	Attach cardiorespiratory monitoring	
	Assess airway and administer oxygen	
	Conduct Initial assessment	
First 15 minutes	Take full bloods	Full bloods not obtained including Venous Blood Gas analysis
	Administer antibiotics IV	Antibiotics not administered until 4 hours 50 minutes after presentation on 10 January 2017
First 30 minutes	IV fluid administration: - repeat within first hour - each time reassess response	Fluid balance including outputs and weight not appropriately measured. Inadequate rate of fluids administered between boluses on 10 January 2017
	Aim to improve heart rate, mentation and perfusion	Vital signs and observations not adequately monitored or recorded over time on any presentation
First 60 minutes	Seek Paediatric Critical Care input	Contact with Cairns Hospital Paediatric Registrar occurred 2 hours and 20 minutes after presentation on 10 January 2017
	Adrenaline infusion *If delay in infusion*: Adrenaline bolus Consider further IV fluid boluses	
	Consider early intubation	
	Correct hypoglycaemia/hypocalcaemia	
	Consider Hydrocortisone	

Figure 5 Sepsis Emergency Management in Children Comparison[46]

[46] Adapted from the Children's Health Queensland Hospital and Health Service, *Queensland Paediatric Emergency Flowchart*, https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/guidelines/sepsis-flowchart.pdf
NB. Table is for illustrative purposes only and should not be utilised as a clinical tool for the treatment of paediatric sepsis.

9.2 Service delivery environment

9.2.1 Communication and culture

Healthcare is often primarily focused on the clinical aspects of a patient's condition and associated treatment. However, this office sees opportunity for Bamaga Hospital, servicing a population that is approximately 75 per cent Torres Strait Islander and 20 per cent Aboriginal, to improve consumer health outcomes through communication.

Communication (both verbal and non-verbal), language, and cultural differences can create major barriers for Aboriginal and Torres Strait Islander peoples in accessing healthcare, particularly in rural and remote locations.[47] A person's health literacy can impact on their understanding of the care that they or their family are receiving, which can dramatically impact their ability to make informed decisions. This is an issue for both the broader population and Aboriginal and Torres Strait Islander peoples. In Charlie's case, communication impacted Charlie's parents' ability to access health services, escalate their concerns, and Bamaga Hospital's ability to recognise parental concern.

Aboriginal and Torres Strait Islander peoples may also be impacted when interacting with the healthcare system by cultural barriers that prevent self-advocacy, which may include difficulty raising issues and challenging authority within the confines of the system. This is in no way a criticism of Aboriginal and Torres Strait Islander peoples, but rather a reflection on the system because it projects certain expectations on how a person will interact if they are concerned or dissatisfied with how care is being provided. The mechanisms for escalating concerns about care often do not account for cultural differences by providing other avenues through which issues can be escalated.

In order to improve health services delivery and outcomes for consumers from diverse cultures, specifically Aboriginal and Torres Strait Islander peoples, the health system and its staff must be culturally competent. This requires an understanding of the patient's cultural views and approaches to health.

Aboriginal and Torres Strait Islander peoples traditionally view their health holistically, which includes consideration of the physical, cultural and spiritual components of their wellbeing.

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[47] Queensland Health, *Aboriginal and Torres Strait Islander: Patient care guideline*, May 2014, https://www.health.qld.gov.au/__data/assets/pdf_file/0022/157333/patient_care_guidelines.pdf

The approach's successful application should involve clinical staff working with the patient's belief system, being aware of their own cultural filters, so they do not misinterpret behaviours and decisions. Accordingly, clinical staff should document any of their patient's cultural views like:

- their concept of health
- their health beliefs related to:
  - wellness and the cause of illness and injury
  - treatment of illness including bush medicines and traditional healers.
  - food beliefs and diet including taboos
  - family/kinship structures, roles and responsibilities
  - death and dying (as relevant)
- cultural and gender-specific protocols and practices.[48]

Further, the Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033 was developed to provide a foundation and guidance for health services to be responsive and deliver culturally competent care. It defines cultural capability as the 'skills, knowledge and behaviours that are required to plan, support, improve and deliver services in a culturally respectful and appropriate manner'. In order to achieve this, the framework recommends four guiding principles as shown in Figure 6.

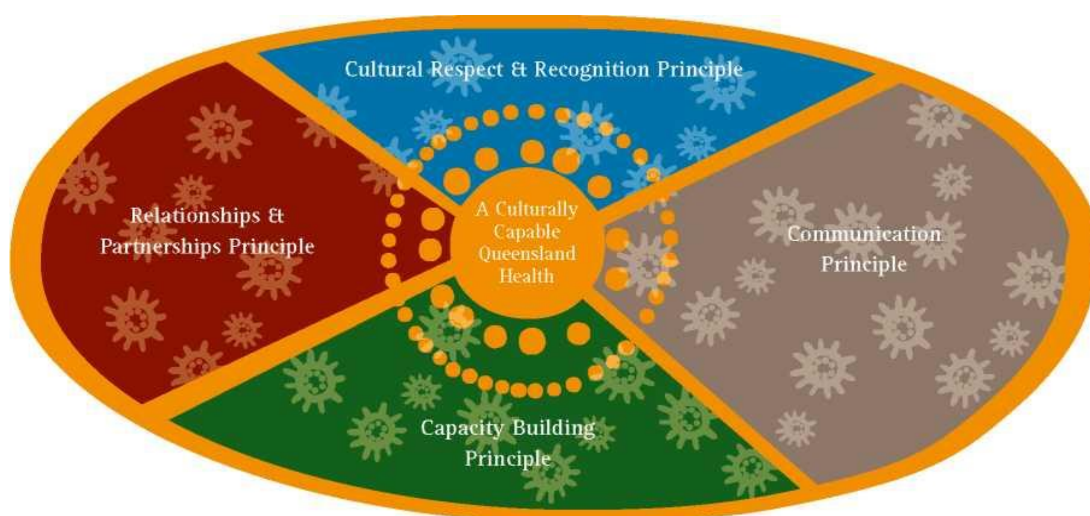

Figure 6 Guiding principles for Queensland Health Aboriginal and Torres Strait Islander cultural capability[49]

[48] ibid
[49] Queensland Health, *Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033*, www.health.qld.gov.au/__data/assets/pdf_file/0014/156200/cultural_capability.pdf

The four guiding principles include:

1. cultural respect and recognition: '*incorporate cultural respect and recognition into Queensland Health's core business'*
2. communication: '*effectively and sensitively communicate with Aboriginal and Torres Strait Islander people through applying culturally sensitive communication and a supportive communication climate'*
3. relationship and partnerships: '*establish relationships and build effective long-term partnerships with other agencies and with Aboriginal and Torres Strait Islander communities and individuals, so that Aboriginal and Torres Strait Islander people can manage and improve their health status'*
4. capacity building: '*build the capability of the health system so that it provides and fosters culturally responsive services to Aboriginal and Torres Strait Islander people'.*

The Australian Commission on Safety and Quality in Health Care released a second edition of the *NSQHS Standards Overview: Guide to better care for Aboriginal and Torres Strait Islander communities*, which addresses gaps in the provision of the health services to Aboriginal and Torres Strait Islander consumers. A range of strategies to support health service organisations implement the changes should assist in efforts to improve their cultural competency.

As a result, six guides have been produced specifically aimed at improving the quality of care and health outcomes for Aboriginal and Torres Strait Islander consumers, they are:

1. setting safety and quality goals for Aboriginal and Torres Strait Islander peoples in health service organisations
2. cultural competence in caring for Aboriginal and Torres Strait Islander consumers
3. improving identification rates of Aboriginal and Torres Strait Islander consumers
4. creating safe and welcoming environments for Aboriginal and Torres Strait Islander consumers
5. effective and safe communication with Aboriginal and Torres Strait Islander consumers
6. comprehensive care for Aboriginal and Torres Strait Islander consumers.[50]

The guides are designed to assist health organisations improve access to, and outcomes from, their services for Aboriginal and Torres Strait Islander peoples in order to reduce the health disparities between this cohort and other Australian demographic groups.

[50] NSQHS Standards, *Overview: Guide to better care for Aboriginal and Torres Strait Islander communities*, 2017, https://www.safetyandquality.gov.au/wp-content/uploads/2016/10/Overview-Guide-to-better-care-for-Aboriginal-and-Torres-Strait-Islander-communities.docx

During the investigation, Bamaga Hospital provided the office with information advising it aligns with the objectives of the TCHHS which include:

- *'providing person centred high quality and safe healthcare*
- *advancing health through genuine partnerships*
- *providing holistic nursing care to patients*
- *maintaining culturally appropriate healthcare delivery'*.[51]

The noted objectives suggest some acknowledgement of and responsibility for meeting cultural competency. However, these approaches were not evidenced in Charlie's case. Specifically, Bamaga Hospital's approach did not appear to exhibit the key factors or guiding principles underpinning cultural competency when Charlie presented to the ED, during his admission and within his clinical records, and even after his passing. The overall evidence suggests that the approach to Charlie's care was not culturally sensitive and has resulted in Charlie's family developing a deep mistrust of the service that will be challenging to repair.

In the context of Charlie's case, the following issues were identified and are discussed in turn below:

- escalation of concerns via Ryan's Rule
- cultural awareness and competence
- consumer partnerships.

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[51] TCHHS, *Welcome to the Northern Peninsula Area: Bamaga Hospital*, 2018

Ryan's Rule

In 2013, Queensland introduced a patient escalation process called Ryan's Rule. It was developed following the death of Ryan Saunders, a three-year-old boy from Central Queensland.

Although Ryan's parents had accessed health services and were provided an initial diagnosis, they believed their son to be deteriorating and in significant pain. Ryan's parents felt their concerns were dismissed and not appropriately considered by the health services involved in his care. Ryan had in fact become seriously ill with a bacterial infection and passed away only four days following his initial visit with his general practitioner. Ryan's Rule has provided families an opportunity to be heard and prevent similar events from occurring. Ryan's Rule is a *'three step process to support patients of any age, their families and carers, to raise concerns if a patient's health condition is getting worse or not improving as well as expected. Ryan's Rule applies to all patients admitted to any Queensland Health public hospital and in some Hospital in the Home (HITH) services'*.[52] (see Figure 7).

Figure 7 Ryan's rule steps

[52] Queensland Health: Clinical Excellence Division, *Ryan's Rule*, https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/ryans-rule

Theoretically, this rule is an excellent escalation measure for patients and/or their families if they are concerned about health issues, and it must be acknowledged that 3753 Ryan's Rules have been called since its inception. However, for Aboriginal and Torres Strait Islander peoples, particularly in remote communities, this is not a culturally competent measure.

It is important to recognise that Aboriginal and Torres Strait Islander peoples may prefer to communicate in ways that differ from other Australians. These differences can encompass a broad range of communication factors including the use and meaning of certain types of language, the importance of rapport between speakers, the manner in which family or kin decisions are made and sharing of private or personal information.[53] Many of these differences are incompatible with the Ryan's Rule escalation model where an Aboriginal or Torres Strait Islander person may find it difficult to engage in a direct discussion and escalation of concerns as required in Steps 1 and 2 of the protocol. Additionally, it has been documented that due to a history of disempowerment, an Aboriginal or Torres Strait Islander person may find such direct disagreement with perceived authority particularly confronting out of fear of giving insult or feeling shame.[54]

These cultural impacts were evidenced during this investigation; Charlie's mother recalled a sense of frustration and confusion having to return each day to Bamaga Hospital only to be turned away without Charlie being properly assessed by a doctor. When staff from this office interviewed clinicians involved with Charlie's care, they commented that Charlie's mother appeared to understand the situation, did not say much, and that she and Charlie were both cooperative. This contrasts with the account from Charlie's mother who advised investigators that she became very upset and angry when Charlie was eventually admitted to Bamaga Hospital. When asked, most clinical staff had no recollection of Charlie's mother ever being angry. The underlying reasons for this disconnect were not identified during this investigation. It is possible Charlie's mother did not feel empowered to make her concerns and anger fully known or, alternatively, clinical staff at Bamaga Hospital may have been unable to interpret and understand her frustration.[55]

There is a Ryan's Rule display in the Bamaga Hospital ED with its information printed in English. It would be more beneficial for the community if patients and their families were advised about the rule in a meaningful and culturally appropriate manner. Both of Charlie's parents told the office's investigators that they did not know how to escalate their concerns about Charlie's deteriorating condition and had no knowledge of Ryan's Rule. It would appear Charlie's parents knew there was something wrong with their son but did not feel that they had a voice.

During a stakeholder meeting on 30 August 2018, Bamaga Hospital highlighted ongoing challenges with informing patients, carers and families about the Ryan's Rule procedure. During local targeted audits,

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[53] Queensland Health: Communicating Effectively with Aboriginal and Torres Strait Islander People, https://www.health.qld.gov.au/__data/assets/pdf_file/0021/151923/communicating.pdf

[54] The word 'shame' carries a particular meaning for Aboriginal or Torres Strait Islander peoples, which is not easily defined. 'Shame' may be felt as a result of embarrassment, fear of being judged or sharing of private or personal information. 'Shame' can occur when a person feels singled out or in circumstances that target a person's dignity. Shame can be disempowering and act as a barrier to seeking help. See https://mhfa.com.au/sites/default/files/ATSI_AdolecentHelp_eversion_2014.pdf

[55] A practitioner involved in Charlie's care submitted *'I very much regret if Charles' parents felt that their concerns about his condition were not acknowledged or recognised by me. I also regret if Charles' parents feel that I did not adequately explain or inform them of Charles' condition and management.'*

even after staff attested that communication about the Ryan's Rule protocol had been delivered upon admission, audit results identified that patients, carers and families were still reporting no awareness of the protocol when surveyed the following day. The causal factors contributing to these results are not fully known. However, Bamaga Hospital indicated cultural and language barriers were likely contributing to the ineffective communication of the procedure to their Aboriginal and Torres Strait Islander consumers, but they were unsure about how to rectify the problem going forward.

There have been past attempts to translate Ryan's Rule into Torres Creole but these have not progressed due to the complexities and numerous dialects of Torres Creole among Bamaga's five communities. The office was advised that there are other consumer support services that could be accessed in similar situations with the assistance of senior facility staff at the hospital and PHCC. These include the Consumer Liaison Officer (CLO) or via the patient satisfaction survey document which is available in Torres Creole. The office has not explored the frequency with which these options are utilised by the community but notes that no Ryan's Rule has ever been initiated at Bamaga Hospital and only three have ever been initiated in the overall TCHHS catchment since inception of the protocol.[56] The most recent of the three occasions was in March 2016.

The absence of a Ryan's Rule ever being enacted at Bamaga Hospital supports the results of the internal audit noted above. Both factors are likely linked to various cultural and language barriers.

While it is acknowledged this issue is complex and difficult to address, it remains an important problem to rectify. TCHHS needs to consider how it can better communicate with Aboriginal and Torres Strait Islander peoples about their escalation processes and develop an action plan for improving the lack of awareness and utilisation of the measures. If not addressed, these barriers may compromise consumer partnership and the detection of deteriorating patients.

9.2.1.1 Cultural awareness and partnerships

Research indicates that Aboriginal and Torres Strait Islander peoples will not necessarily engage with the healthcare system if they do not have an established rapport and trusting relationship. For example, gathering information about a patient's identity and reason for their presentation to hospital is a required process. Yet for an Aboriginal or Torres Strait Islander patient, being open and disclosing personal and private information may be hindered unless rapport and trust has been established. The patient's hospital experience will impact on their feelings of safety in accessing services, influencing whether they or their family will access those health services again in the future.

To address cultural awareness, all Bamaga Hospital staff are required to complete a cultural awareness program that would be expected to be completed at any Hospital and Health Service (HHS) in Queensland. This involves a compulsory online and face-to-face cultural practice program for all staff, which is undertaken once and can be completed over a six-hour period. While it is positive that there is some cultural awareness training, it may be insufficient to prepare an inexperienced clinician to provide culturally competent care in this region.

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[56] While a total of five Ryan's Rules are recorded by TCHHS since the protocol began, one of these was for service not provided by a TCHHS facility and two were recorded for the same patient approximately 32 minutes apart.

It has been reported that cultural awareness alone does not lead to improved health outcomes.[57] An appropriate response would see hospitals implement practices and policies that recognise cultural competency as a holistic and imbedded component of hospital care.

One approach considered to improve culturally sensitive care is where a health service undertakes an honest self-assessment of its current status as a culturally sensitive organisation by examining its communication in partnership with communities.[58] Any changes should be developed together with the Aboriginal and Torres Strait Islander communities to support genuine consumer engagement, assist with building trust, and ensure the health service listens and responds to their views. The development of any formal protocols needs to be carried out with Elders and key stakeholders within the community.

Consumer partnerships should be a central focus for the Bamaga Hospital and the community should feel confident that the hospital understands them, and will deliver culturally safe, high-quality care they can trust.

When investigators from this office queried Bamaga Hospital's communication strategies, the hospital submitted that nearly 50 per cent of their staff speak Torres Creole. Being the predominant language in the region and in the context of Charlie's care, the indication was that Charlie's mother should have had access and support to engage with staff in her primary language.

However, when investigators further reviewed Bamaga Hospital's claims of Torres speaking staff, it was identified they were all non-clinical roles, namely groundskeepers and cleaners. It is concerning Bamaga Hospital considers this to be an appropriate response when issues could arise around confidentiality. It also raises concerns about a lack of consideration for community kinship and family structures, and suggests a limited understanding of the potential cultural factors of Bamaga's community despite cultural awareness training.

At the time of Charlie's incident there was no CLO at Bamaga Hospital, nor was there access to one from another site as an option to provide additional support to the family when it became clear Charlie's condition was serious. It has only been since early 2018 that the TCHHS has recruited a CLO to be a strong cultural link between the community and health service staff, with the view to improving the experience of the community and facilitate health service staff to better service the community. The position is located on Thursday Island with the role only supporting the Northern region of the TCHHS including Bamaga.

In accordance with the Aboriginal and Torres Strait Islander Patient Care Guidelines, CLOs play a pivotal role in providing support and assistance to Aboriginal and Torres Strait Islander patients including:

- practical and emotional support
- advocacy
- referrals and discharge planning

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[57] Report: Australian Institute for Primary Care, *Improving the Culture of Hospitals Project*, Final report 2010, https://www.lowitja.org.au/content/Document/PDF/ICHP_Final_Report_August_2010.pdf
[58] ibid

- cultural safety and connection
- helping patients understand information relating to their hospitalisation and treatment
- language support.

During a stakeholder meeting with Bamaga Hospital on 30 August 2018, investigators were advised that although the CLO was based on Thursday Island, consumers could access this person over the telephone 24/7. In consideration of both internal review processes that were undertaken in mid-2018 (to be discussed in section 9.3 of this report), it has been noted Charlie's family were not aware of the CLO, the purpose or the potential support that could be provided to them, nor did the CLO reach out to them on behalf of TCHHS during this investigation.

The facility manager also advised the investigators that expressions had been circulated in the past to the NPA region in an attempt to secure an Aboriginal CLO representative, as the current CLO has a Torres Strait Islander background. However, the communities did not respond. The approach taken by Bamaga Hospital to fulfil this position was not expanded upon, only that historically engaging with the community in this area has been challenging and there was no current plan or solution.

The latest NSQHS Standard for Partnering with Consumers now includes actions that specifically focus on meeting the needs of Aboriginal and Torres Strait Islander peoples. The effectiveness of consumer engagement activities should be monitored and evaluated to ensure their purpose is aligned with the hospital's and the community's vision for delivering quality and safe healthcare. The TCHHS should consider, in partnership with the Bamaga community, a review of the current CLO's role and responsibilities to ensure it is meeting its purpose.

9.2.2 Model of care

When a patient is treated in a healthcare environment their treatment will follow a model of care and/or treatment pathway. This approach to providing care aims to ensure people get the right care, at the right time, by the right team and in the right place.

This important interface between the community and the health facility often begins with the ED. The role and level of function of a hospital-based emergency service depends on various factors, including the type of facility in which it is located, geographical location, location in the public or private sector, and the place of the facility within a health system network.[59]

Bamaga Hospital has advised this office that their models of care align with the TCHHS's broader objectives of providing person-centred and holistic care to patients. The following discussion illustrates the differences in Bamaga Hospital's approach to delivering care including:

- ED model of care
- medical model of care for the hospital.

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[59] Queensland Health, *Emergency services, CSCF, v3*.2, https://www.health.qld.gov.au/__data/assets/pdf_file/0027/444276/cscf-emergency.pdf

This discussion also provides context for this office's observation that the models of care being used by Bamaga Hospital do not appear to meet the needs of the community. Charlie's case suggests that the ED is not currently servicing the community to provide complete 24/7 medical care that fits within their CSCF capability.

9.2.2.1 Bamaga Hospital's emergency department

Bamaga Hospital is a 24/7 designated Level 2 ED. As a facility, it is equipped to provide various types of emergency care. However, patients presenting with very serious medical conditions are typically stabilised and transferred to the nearest appropriate tertiary or higher-level facility.[60]

Most EDs operate within a hospital and are often the first point of contact for particularly sick or injured patients. They are purpose designed to administer unplanned and unscheduled urgent care and are required to have 24-hour dedicated nursing staff and, at a minimum, access to medical staff after hours. There are various models in which rural EDs, such as Bamaga, function. These models often reflect the overall rural and remote environment in which they are located and account for factors such as staffing, resourcing, clinical service capabilities and a range of demographic and cultural factors of the community they service.

Regardless of the applied model, a fundamental principle of an ED is that only patients requiring emergency care should be managed there.[61] [62] Patients requiring other types of care should be referred to the appropriate services within the hospital or, if applicable, to another service outside of the facility such as a PHCC. Any departure from this core ED principle must be very carefully considered as it may contribute to congestion, disrupt efficient and safe patient flow, reduce staff confidence in the ED model and increase the risk of poor compliance with ED business rules and protocols.

All patients who present to any Queensland Health ED should be triaged by a qualified triage nurse and assigned to a category according to the Australasian Triage Scale (ATS). There are five ATS categories:

- ***Category 1**: Immediate patients experiencing life-threatening illnesses or injuries that require immediate attention*
- ***Category 2**: Within 10 minutes patients who require urgent attention and may be seriously ill or injured*
- ***Category 3**: Within 30 minutes patients with serious illness or injury who are in a stable condition*
- ***Category 4**: Within 1 hour patients who are not in immediate danger or severe stress*
- ***Category 5**: Within 2 hours patients who have presented with a non-emergency health concern.*

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[60] ibid
[61] Australasian College For Emergency Medicine, *Emergency Department Design Guidelines,* https://acem.org.au/getmedia/faf63c3b-c896-4a7e-aa1f-226b49d62f94/G15_v03_ED_Design_Guidelines_Dec-14.aspx
[62] NSW Health, *Emergency Department Models of Care*, 2012, https://www.health.nsw.gov.au/Performance/Publications/ed-model-of-care-2012.pdf

Triage is an important process as it facilitates efficient allocation of resources to patients most in need of urgent care.[63] Triage usually occurs soon after the patient arrives at the ED and, if necessary, should also include continuous reassessments of any waiting patients. An effective triage process is a key component to the management of hospital resources and patient crowding.[64]

ED congestion is recognised as a major patient safety concern associated with poor patient outcomes.[65] During this investigation, multiple sources indicated that at the time of Charlie's care, Bamaga Hospital's ED was experiencing significant congestion. One practitioner stated that the ED was '*extremely confusing and chaotic*'.

This account is further verified by information obtained from another medical practitioner involved in Charlie's care, who indicated a culture of suboptimal triage practices at Bamaga Hospital, including an overall lack of detail within triage notes. In reference to Charlie's second recorded presentation on

Tuesday 10 January 2017, the practitioner indicated that with regard to Charlie's re-presentation on that day as an unwell six-year-old child, the practitioner was not alerted to his attendance, he was triaged as a category 4 and never prioritised for medical review even though he had presented the previous day.

At the time of Charlie's care, Bamaga Hospital routinely managed patients other than those requiring emergency care through their ED. This included a dedicated hospital process for non-urgent planned ED representations[66] and a broader entrenched culture of managing patients from the community who, for various underlying reasons, would attend the ED whenever they needed to see a doctor or simply required medication.

This office was advised by an LMO that the hospital preferred to receive all patients from within the community rather than referring patients back to the PHCC when there was clearly no emergency. Apparently, it was understood within the community that if someone presented at the hospital wanting to see a medical officer then they needed to attend in the morning or afternoon when a medical officer was on shift. This approach appears to completely defy the purpose and model of care of an ED in a hospital.

The negative impact these factors may have on patient congestion and clarity of roles or expectations for practitioners working within the ED has been identified as a contributing factor to a number of issues identified in Charlie's case.

It is acknowledged that a degree of flexibility may be necessary for rural and remote facilities when applying their limited resources in a community that is accustomed to certain patterns of service use. However, it is imperative that an ED, purposed for a particular type of care, is an explicit function at Bamaga Hospital with clearly defined governance, business rules and department protocols. Managing

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[63] Queensland Health, *How Emergency Departments Work: The Triage System*, https://www.health.qld.gov.au/news-alerts/news/emergency-departments-triage
[64] Queensland University of Technology, *Emergency Health Services Demand & Service Delivery Models*, https://eprints.qut.edu.au/46643/1/46643.pdf
[65] Queensland Health, Clinical Excellence Division, *Emergency Department Models of Care Review*, 2018, https://clinicalexcellence.qld.gov.au/sites/default/files/docs/reviews/ed-models-of-care-review-2018.pdf
[66] Planned representation care includes pathology, wound care, blood sugar level and visual acuity tests.

the flow of patients not requiring emergency care to more appropriate health services will be an important patient safety undertaking at Bamaga Hospital.

Bamaga Hospital's model of care

Bamaga Hospital has advised the office that it operates a medical model of care which traditionally involves medical officer-led treatment and less partnering with the patient in developing the care and treatment pathway. This approach does not align with TCHHS's commitment to provide culturally competent, person-centric and holistic care. However, this focus should be shifting given the NSQHS Standards require partnering with consumers to be a central tenant of modern healthcare delivery.

Bamaga Hospital has acknowledged there is a need to explore other model of care options, including the nurse practitioner (NP)[67] model of care, with scope for increasing consumer participation and consultation. The NP model of care may also improve the chronic disease issues that continue to be overrepresented in Aboriginal and Torres Strait Islander communities as NPs can assist patients in the management of their chronic disease conditions in the clinics closer to their homes. This has been demonstrated to improve patient participation and accessibility. NPs focus on providing comprehensive assessments and supporting self-management including education about lifestyle modifications as well as education review and adjustment. NPs can also collaborate and coordinate care with GPs and specialty teams. Particularly in remote communities, the NP model of care can provide greater continuity of care and fill a much needed gap due in part to a shortage of medical practitioners despite government initiatives to encourage work in rural and remote areas.[68]

The management of chronic disease (e.g. cardiac disease, respiratory illness and diabetes with subsequent chronic kidney disease) in community settings is a major area of focus for Bamaga Hospital and they are aware of the need for improvements in the models of care aimed at supporting appropriate chronic disease management in the community. They are also aware of the need for increased health promotion to improve the population's health literacy.[69]

It is concerning that the PHCCs within this community are currently underutilised for routine healthcare. This places added pressure on the hospital, forcing medical staff to manage routine clinical presentations that should be more appropriately managed in the PHCC.

Bamaga Hospital's model appears to have impacted Charlie's ability to access timely and appropriate care. It will continue to have an impact on the community until such time that Bamaga Hospital, the PHCCs and TCHHS define models of care and where and how care will be delivered to better meet the needs of the community.

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[67] A nurse practitioner (NP) is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. For example, a nurse practitioner can order tests and write prescriptions for certain medications.

[68] 13th National Rural Health Conference, *Evolution of the nurse practitioner role at a rural health service*, http://www.ruralhealth.org.au/13nrhc/images/paper_James%2C%20Wendy_Morcom%2C%20Mandy.pdf

[69] Health literacy is about how people understand information about health and healthcare, and how they apply that information to their lives, use it to make decisions and act on it.

9.2.3 Inducting clinical staff and resourcing

9.2.3.1 Induction

At the time of Charlie's care in 2017, Bamaga Hospital was utilising temporary medical officers to provide medical care at both the hospital and within the PHCC. The orientation of these staff was critical to ensuring that staff understood the environment in which they would be working, had knowledge of the expectations on them when working at the hospital, and were consistent in their approach to providing clinical care.

During this investigation, the office was provided with several orientation documents available for new TCHHS staff including:

- *Welcome to Bamaga Hospital Doctors Clinical Orientation Guide (Under construction)*
- *Bamaga Hospital Nursing Orientation Package Welcome to the NPA*
- *TCHHS Employment welcome pack*
- *Welcome to Bamaga Hospital contact numbers and overview of the five Aboriginal and Torres Strait Islander communities*
- *TCHHS Agency and Temporary Nurse Pool Orientation and mandatory training program*.

Bamaga Hospital also had their own local doctor's clinical orientation guide which contained the following:

- information about the outpatients/GP, inpatients, and high dependency areas
- an overview of patient transfer instructions, pharmacy, pathology, and radiology
- information technology access and programs
- specialist referrals and clinic information
- information about the pathology of the Cape including ARF, poststreptococcal glomerulonephritis, melioidosis, snake bites, and STD/Is
- important contact details.

To facilitate orientation, the TCHHS employment welcome pack explains that orientation will be delivered via face-to-face and/or video conferencing program and must be completed within the first 30 days of employment.

While the above orientation documents and procedures appear sufficient, investigators were unable to ascertain whether they were routinely followed. For example, when interviewing the LMOs that were directly involved with Charlie's care, they explained that the orientation at Bamaga Hospital only consisted of a tour of the hospital and verbal briefing on how a typical day would operate. They reported they were not provided with any formal orientation and did not receive any of the documents provided to this office by TCHHS, demonstrating a significant gap, at that time, with the orientation protocols.

It is acknowledged the LMOs placement was short term. However, Bamaga's remote location, the cultural competence required to manage most consumers, and the local health issues present in the community place greater importance on ensuring clinical staff working at the hospital or the PHCC are properly oriented to their environment.

It is clear on reviewing the TCHHS orientation documents that they have an appropriate foundation for orientation that would provide staff with the necessary support – assuming that the orientation process is actually applied in practice. However, there are several orientation documents which could be burdensome for clinical staff in reviewing prior to commencing employment with TCHHS. Additionally, when the office reviewed the Bamaga Hospital orientation documents it appeared that some of the information was obsolete, which has the potential to create confusion in the orientation process. These local documents need to be reviewed and updated using a regular document review schedule to prevent dissemination of expired information and processes.

There is also a level of responsibility on the medical officer to gain an understanding of their pending duties. However, if TCHHS ensures all locums are aware of the same information, a greater level of support and awareness would be shared and the risk to patient safety may reduce. Given the importance of orientation to the overall operation of the hospital, all clinical staff whether they are permanent or temporary, should have access to consistent information, including the cultural components that would assist with the delivery of healthcare at the Bamaga Hospital and to their Indigenous community.

In addition to the impact on working methods, orientation is also central to providing a safe workplace. It provides an opportunity for staff to clarify information, understand local processes, and support positive culture through the consistent application of policies and procedures and approaches to clinical care.

9.2.3.2 Recruitment

As noted above, in 2017 Bamaga Hospital used temporary medical officers, otherwise known as LMOs, to fulfil its medical staff requirements due to roster shortages over the Christmas period. Often, locums fill positions for respite and relief or when a health service is experiencing difficulties retaining or attracting permanent medical staff. The LMOs were arranged by the Rural and Remote Clinical Support Unit (RRCSU) in collaboration with Queensland Health's Locum Medical Officers, and through other standing agreements with locum agencies.

The reliance on LMOs in Bamaga shifted in June 2018, with the appointment of three permanent senior medical officers (SMOs). They were recruited to provide a stable medical workforce, enable on-call arrangements to be sourced locally, and cease reliance on LMOs.

The Northern Director of Medical Services, TCHHS, advised that a brief was being submitted to convert a fourth SMO position occupied by a senior GP registrar to permanent, indicative of this arrangement's success to date.

Permanently appointing SMOs is a significant positive improvement in Bamaga, with the hospital reporting to the office that their consumers will now have increased continuity in patient care, improved compliance with hospital policy and procedures, and that clinical staff have a greater awareness of local issues.

Although the medical staffing arrangements have recently changed at Bamaga Hospital, TCHHS needs to ensure it has a plan for instances where reliance on locums may be necessary, which should include a level of orientation/induction that is delivered regardless of the deployment length. This should be aimed at, as far as practicable, seeking to secure continuity in care so that there is appropriate handover between clinicians and compliance with policies and procedures. It would provide a basis for appropriate records maintenance that allows all relevant information to be considered to properly manage a patient's care.

9.2.3.3 Rostering

During interviews, the LMOs involved with Charlie's care advised that the hospital environment was disorganised, including clinical staff being required to decide duty placements among themselves (i.e. in the hospital or the PHCC). In reviewing the medical rosters at this time, a clinician's shift did not describe the hours to be worked or indicate whether placement would be at Bamaga Hospital or Bamaga PHCC.

While this provides staff with a satisfactory means to request their hours and locations, some oversight of the rostering is required to ensure that there is appropriate staffing at the two facilities. Rostering is an important element to ensure a health facility provides high quality and safe care. It ensures sufficient numbers of appropriately skilled staff are scheduled to work and provide the right patient care and meet service demands. Clinicians should feel confident they will be placed in a safe environment to undertake their duties. It also facilitates the appropriate provision of adequate staff supervision, training and clinical handover.[70]

Bamaga Hospital's current approach to rostering is considered problematic, because it limits the hospital's capacity to optimise staffing allocations to meet patient needs, potentially causing discontinuity of care and poor clinical record keeping. The office has received no evidence from TCHHS or Bamaga Hospital to demonstrate any change to the rostering process.

9.3 Post-incident management

9.3.1 Clinical governance

The Australian Commission on Safety and Quality in Health Care defines clinical governance to be the '*set of relationships and responsibilities established by a health service organisation between its governing body, executive, clinicians, patients and consumers, to deliver safe and quality health care. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care and continuously improve services.*'[71]

As the definition suggests, clinical governance starts at the top of a health service. Accordingly, the TCHHS Board is ultimately responsible for ensuring strong clinical governance processes are implemented across the health service and are directly accountable to the Minister for Health and Parliament for these responsibilities, which are set out in the *Hospital and Health Boards Act 2011* (Qld).

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[70] NSW Health, *Principles of rostering*, https://www.health.nsw.gov.au/Performance/rostering/Pages/principles.aspx
[71] NSQHS Standards, *National Model Clinical Governance Framework*, https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf

The Board is also responsible for corporate governance and formulates strategy, sets policy, delegates responsibility, oversees management, and ensures appropriate risk management and accountability arrangements are in place throughout the organisation.

A major part of the clinical and corporate governance responsibilities of a health service is undergoing accreditation against the NSQHS Standards. The TCHHS met their accreditation in September 2017 and this accreditation remains in force until 1 November 2021. When a health service, such as TCHHS, is accredited the process looks for examples of practice that meet the accreditation standards across the entire service. As such, the accreditation report produced for TCHHS is demonstrative of the whole service's quality and does not specifically address whether Bamaga Hospital as a facility met all of the NSQHS Standards as part of accreditation.

The NSQHS Standards, through the National Model Clinical Governance Framework (the governance framework) provide significant guidance on what is expected of a strong clinical governance system. However, these tools do not instruct a health service on how it should develop and implement clinical governance systems. The reason being that the governance framework has been designed so health services can adapt and implement strategies to best meet the needs of their consumers and organisation. To meet local requirements and to drive continued improvement, governance systems should not remain static, but be regularly reviewed and evaluated.[72]

The governance framework emphasises that good governance is comprised of several essential elements, including:

- governance, leadership and culture
- patient safety and quality improvement systems
- clinical performance and effectiveness
- safe environment for the delivery of care
- partnering with consumers.[73] In TCHHS, the TCHHS Safety and Quality Committee supports the Board, and the TCHHS Clinical Council provides a formal mechanism for clinician involvement and input into strategic and governance matters by providing expert clinical knowledge and advice to the executive management team and Board. These are two of the key, high-level components of the clinical governance system, which should be aimed at securing good clinical outcomes through accountability of safe, effective, high quality and continuously improving health services. The TCHHS Quality and Safety Committee Governance Structure is below in Figure 8.

[72] Safer Care Victoria, *Delivering High-Quality Healthcare, Victorian Clinical Governance Framework, June 2017*, https://www.bettersafercare.vic.gov.au/sites/default/files/2018-03/SCV%20Clinical%20Governance%20Framework.pdf
[73] ibid

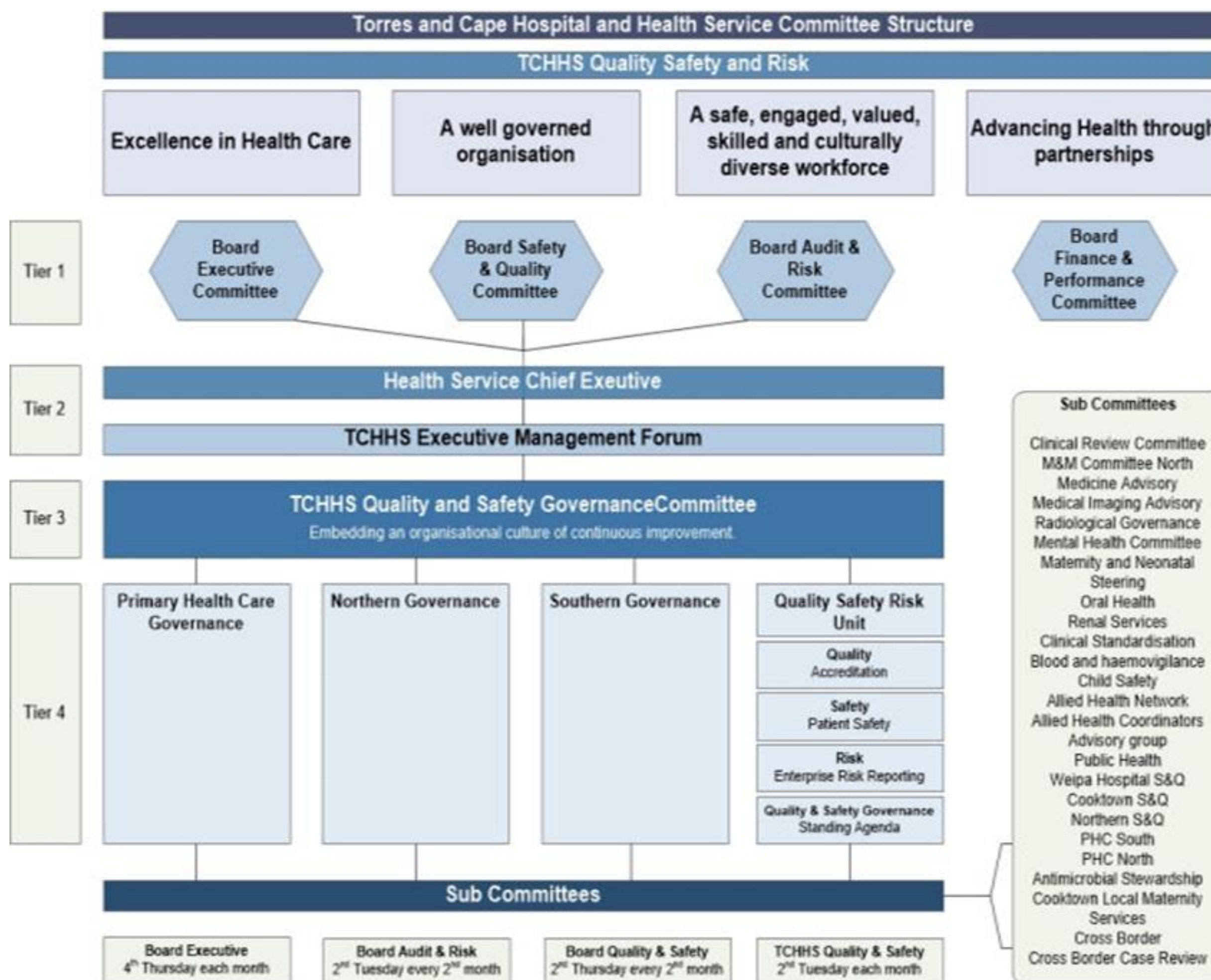

Figure 8 Torres and Cape Hospital and Health Service Quality, Safety and Risk governance structure

During the course of this investigation, there have been changes to the TCHHS executive structure. The Board decided to spread its executive members across the region in mid-2018 for a more balanced distribution. The accreditation report expressed some concerns with this approach noting that it may ‘reinforce parochial thinking’. However, the report did not elaborate further on this point.

The most recent and significant change has been the appointment of a new Board Chair in May 2019. It has been reported that the Chair has a cultural connection to the region and has indicated that improving health outcomes requires a deep understanding of Aboriginal and Torres Strait Islander peoples and their lives.[74] With the governing body of TCHHS engaging a Chair who has a unique understanding of

[74] *Torres News*, Thursday Island, 31 May 2019

the cultural nuances of the largest proportion of the population in the TCHHS catchment, this is expected to generate positive changes.

Bamaga Hospital is led by the Director of Nursing/Facility Manager, who is broadly responsible for advising and informing the governing body and operates the facility within the strategic and policy parameters indicated by the TCHHS. The issues identified in relation to Charlie's care, followed by the approach taken by Bamaga Hospital after his passing, highlighted clinical governance deficiencies with incident response processes.

9.3.2 Clinical incident review

On 16 January 2017, Cairns Hospital advised Bamaga Hospital of Charlie's passing. It was reported that in response, clinical staff at Bamaga Hospital undertook an informal debrief meeting on Wednesday 18 January 2017, which included discussion of the case timelines, management by the clinicians involved, and the anticipated impact on Charlie's family, community, and the team at Bamaga Hospital and PHCC. This meeting was not documented and recollections of the discussion details vary among the attending practitioners. Some individuals involved in his care stated that no formal internal discussions ever took place.

Charlie's passing was not categorised as an incident by Bamaga Hospital or TCHHS, and was not initially progressed in accordance with the TCHHS *Clinical Incident Management Procedure*. This lack of categorisation as an incident highlighted a potential gap in the TCHHS incident management framework in relation to deaths that occur outside of the HHS but are possibly connected to the healthcare provided by it.

Under the procedure, and in accordance with Queensland Health's *Best Practice Guide to Clinical Incident Management*, Charlie's passing should have been identified as a clinical incident because it was not reasonably expected from the healthcare provided. The primary objective for identifying and managing Charlie's passing as an incident is to ensure that a similar incident does not recur. Appropriate management of an incident can also assist clinicians, families and carers to understand the reasons for the incident, which is an important element of accountability and system improvement in modern healthcare.

TCHHS did undertake a formal incident analysis of Charlie's care. However, this was only after a complaint was made to this office. The expected timeframe for an analysis is 90 days after the incident was reported, but the first incident review in this matter was completed by TCHHS on 31 May 2018, some 501 days after Charlie's passing was notified to the HHS (see Figure 9, Timeline comparison of events following Charlie's passing, at the end of Section 9.3.2).

It is highly likely the significant 16 month delay in the formal review undermined TCHHS's ability to obtain an accurate and contemporaneous account of Charlie's care and any associated issues. This is evidenced by multiple practitioners during this investigation caveating their recollection of the events relating to Charlie's care as being compromised due to the time elapsed since the incident.

The delay also undermined the TCHHS's responsibility to put Charlie's family at the centre of the response. Early family engagement following Charlie's passing may have identified important issues,

including the alleged earlier presentations. TCHHS's failing to sensitively respond to the event in a timely manner directly impacted both its ability to identify his family's concerns, and recognise that Charlie's passing should have been classified as a Severity Assessment Code 1 (SAC 1)[75] incident.

With the requisite criteria for the threshold of a SAC 1 event being met, the lack of local processes following notification of Charlie's passing was a critical failure by TCHHS in complying with the procedure and ensuring that there was an appropriate incident management response to prevent similar incidents going forward. It is also clear, based on the evidence of various staff, that there was significant confusion and a lack of clarity about what, if anything, was being done in response to Charlie's passing. This is an unacceptable situation in response to a serious adverse event in a modern healthcare system and demonstrates a lack of maturity and sophistication in the TCHHS clinical incident management framework. This requires urgent improvement.

TCHHS undertook a Human Error and Patient Safety review (HEAPS)[76] first, followed by a Root Cause Analysis (RCA).[77] The completed RCA report was provided to this office on 18 October 2018, almost two years after Charlie's passing. The second review by TCHHS was commenced because subsequent to the correspondence between our office and the TCHHS, a clinician who saw Charlie at Bamaga Hospital on 9 January 2017 suggested there may have been earlier presentations not documented in the clinical records. This issue had the potential to change the conclusions of the incident review so the further review was necessary to explore this additional information.

Aside from the concerns discussed above, with the delay in TCHHS classifying Charlie's care as an incident, the office also identified issues in relation to:

- the quality of the HEAPS report
- the quality of the RCA analysis
- the lack of a death review.

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[75] TCHHS SAC 1 incident is defined as '*death or harm that is likely to be permanent and is not reasonably expected as an outcome of healthcare*'. 'Reasonably expected' can relate to the perceptions of the patient, family, carer and/or clinicians.
[76] A HEAPS analysis is a concise clinical incident analysis tool which is designed to produce timely and accurate corrective actions in response to an event, by considering contributing system and human factors.
[77] An RCA is a structured and detailed process by which a chronology or sequence of a clinical event is established to develop a cause and effect matrix. Recommendations are then formulated to reduce the likelihood of a similar adverse event occurring. Commissioned RCAs pursuant to the *Hospital and Health Boards Act 2011* (Qld) are confidential undertakings with protections on the contents of the investigation and recommendations.

HEAPS report

Identification of issues

The HEAPS analysis conducted by TCHHS identified four main issues in Charlie's case:

- the 9 January presentation lacked documentation in relation to the care plan or a description of care advice to Charles' parents
- the lack of arterial blood gases collected during Charles' admission may have prompted escalation to sepsis pathway[78]
- no formal internal escalation procedure was in place that outlined required clinical communications between TCHHS medical executive and frontline medical officers. Such a procedure would support decision making of clinical care related to the timeliness of emergency retrievals
- the death review procedure that would trigger follow up with families was not conducted because the child died in another HHS region.

From these identified issues, three recommendations were made:

> **Recommendation 1:** the paediatric sepsis pathway is included as part of clinical induction processes
>
> **Recommendation 2:** the procedure for escalation and transfer to higher levels of care is published
>
> **Recommendation 3:** the death review process includes records of those who died within another HHS and were seen at a TCHHS facility within 30 days of death. Requirement for family follow up is indicated through this process.

As has been detailed above, one of the key issues in this case was the allegation that Charlie presented to Bamaga Hospital as early as Thursday 5 January 2017, but that if not on that date then certainly by Saturday 7 January 2017, and that these presentations were undocumented. This contention should have been known to TCHHS as it formed part of the complaint to the office, a copy of which was provided to TCHHS on 4 June 2018 in accordance with our normal complaint management processes.

Despite this awareness, TCHHS failed to explore this issue in the HEAPS analysis and instead proceeded on the basis that Charlie's care commenced on 9 January 2017. Considering the potentially serious implications of Charlie's earlier undocumented presentations, this office would have expected TCHHS to thoroughly explore this issue through its analysis. Such exploration may have included discussions with staff and the family.

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[78] Sepsis flowchart was implemented in August 2017.

The office sought clarification from TCHHS on this issue, which has affirmed that as the clinical documentation does not demonstrate an earlier presentation or any references that suggest an earlier presentation then it is reasonable to conclude that 9 January 2017 was the earliest date of attendance. As outlined in section 3.1.2, this office does not concur with TCHHS's conclusion.

Implementation of recommendations

During this investigation, TCHHS indicated that all recommendations from the HEAPS analysis were scheduled to be completed by 30 July 2018.

The first recommendation was recorded as completed in August 2018, although the clinical orientation and induction material TCHHS submitted to the office on 19 November 2018 did not support this. It was further reported the second recommendation was still in draft form and awaiting executive action and the status of the final recommendation was still pending at the end of 2018. The office has received no further updates.

Recommended action implementation is a critical step in the incident management process. A thorough process should also follow with a review of the implementation evidence, and testing of the efficacy of the recommendation in addressing the underlying issue.

A delay in recommendation implementation has the potential to leave the identified risk unresolved. The first and second recommendations stemming from the TCHHS HEAPS analysis were important patient safety recommendations, yet they were not progressed in the prescribed timeframes or appropriately evidenced in the relevant documentation provided to the office during this investigation.

9.3.2.1 RCA analysis

Details of the RCA investigation relating to Charlie's care cannot be discussed in this report. Commissioned RCAs pursuant to the *Hospital and Health Boards Act 2011* (Qld) are confidential undertakings with protections on the contents of the investigation and recommendations. However, this office observed that the analysis of the issues within the RCA failed to adequately address the assertions of Charlie's parents that they presented at Bamaga Hospital on 5 January 2017. Given this was the purpose of the additional review, this appears to be a major unresolved issue.

9.3.2.2 Death review

When a patient dies unexpectedly within a Queensland public hospital there are a number of related actions that must be undertaken in accordance with legislation and HHS procedures. Hospital deaths may also be subject to an internal death review process. No such review was completed by Bamaga Hospital or TCHHS due to the gap in the incident management processes caused by not recognising the significance of Charlie's passing to their facility when it occurred in another HHS.

Deteriorating patients who are initially treated within a rural or remote facility with the capability level of Bamaga Hospital will likely be transferred to a higher-level service. As with Charlie's care, this may involve a transfer outside of the HHS altogether. TCHHS identified during its HEAPS analysis that the review process that would normally occur as a result of a death was not triggered due to Charlie's transfer and subsequent passing within another HHS's catchment. Appropriate identification may have

facilitated a timely and independent review of Charlie's care, and importantly, the appropriate engagement and communication with his family.

Although action has been subsequently taken by TCHHS to rectify this gap, there is still scope for further improvement. Specifically, the trigger for a review should be extended to capture all serious clinical incidents, not just an unexpected death. This would mean that a patient who suffered harm not reasonably expected as an outcome of healthcare provided by TCHHS would still be subject to an appropriate review regardless of whether they were transferred to another HHS during their care. The scope for this should be linked to the incident classifications as defined by Queensland Health.[79]

To ensure that when incidents are identified they are properly addressed there needs to be a strong governance framework in place, regardless of the location in which the death or serious harm occurred. There is significant work for Bamaga Hospital and TCHHS to undertake to mature this aspect of its incident management framework.

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[79] Queensland Health, Clinical Excellence Division, *Best Practice Guide to Clinical Incident Management*, June 2014, https://clinicalexcellence.qld.gov.au/sites/default/files/2018-01/clinicalincidentguide.pdf

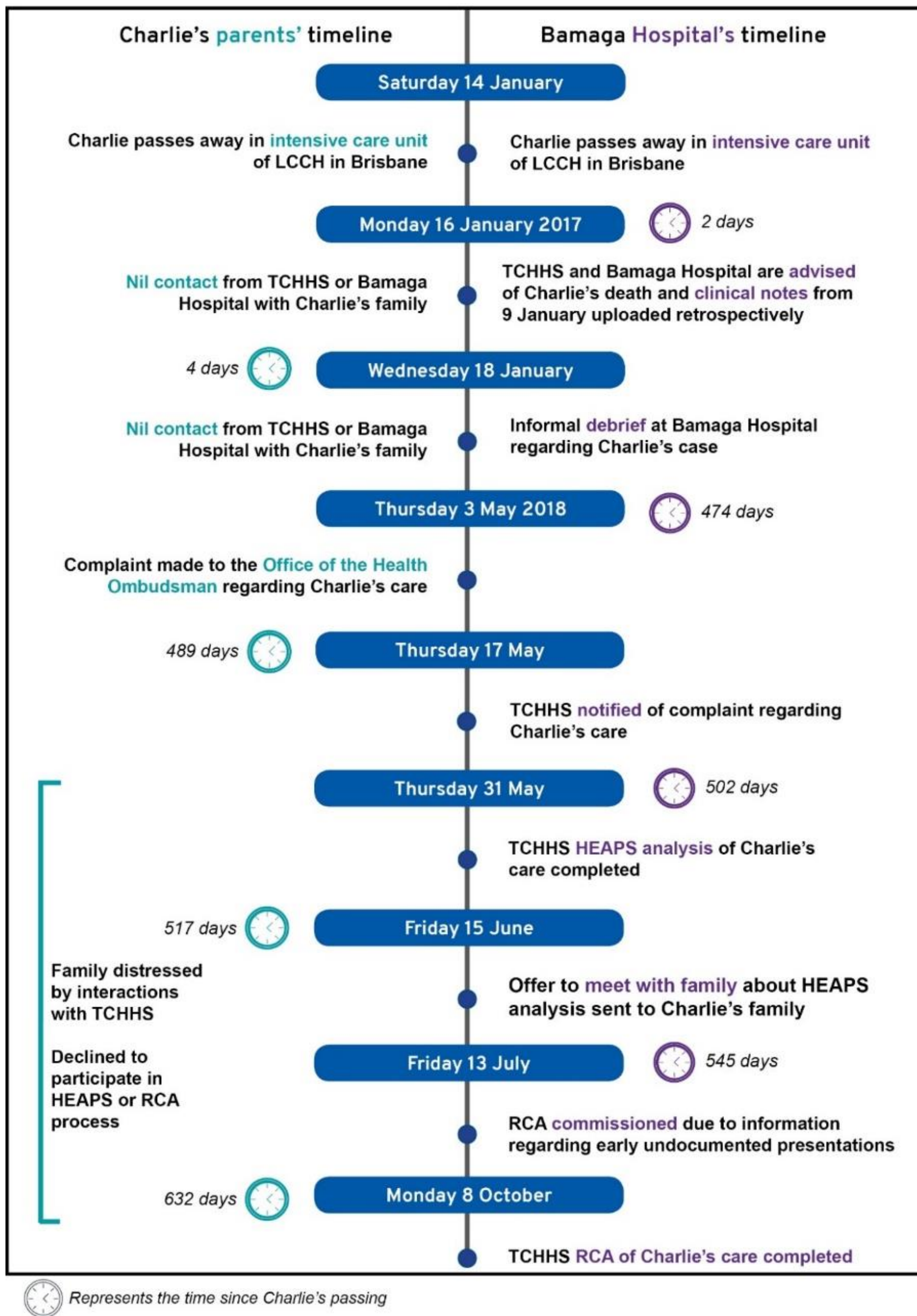

Figure 9 Timeline comparison of events following Charlie's passing

9.3.3 Open disclosure

'*Open disclosure describes the way clinicians communicate with and support patients, and their family and carers who have experienced harm during health care.*'[80] Timeliness is an important element of open disclosure. However, owing to the delay in Bamaga Hospital recognising Charlie's passing as an incident related to the healthcare he received at the hospital, open disclosure was not initially offered to his family. Only after conclusion of the RCA analysis did TCHHS plan to undertake an open disclosure process with Charlie's family, some 21 months after his passing. There were issues with the open disclosure process and Charlie's family ultimately declined to participate in any discussion with the hospital.

Open disclosure is a challenging process for all those involved, which is why a strong framework and consistent method needs to be in place and practised. It is also important for a health service to provide appropriate support mechanisms for its staff in planning and participating in open disclosure, as for many, this may be an infrequent activity. The TCHHS has an added layer of complexity due to its population demographics as it needs to ensure that the open disclosure processes are also culturally appropriate to support its Aboriginal and Torres Strait Islander consumers.

The following discussion outlines:

- the Australian Open Disclosure Framework
- Queensland Health's '*Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying'*
- TCHHS's approach to open disclosure.

9.3.3.1 Open disclosure framework

The NSQHS Standards require all public hospitals and health services to develop or adopt an open disclosure process that is consistent with the Australian Open Disclosure Framework (the open disclosure framework).[81] The open disclosure framework was released in 2013 and *'provides a nationally consistent basis for communication following unexpected health care outcomes and harm. It is designed so that patients are treated respectfully after adverse events'*.

The open disclosure framework acknowledges that open disclosure is inherently complex, but notes that when it is undertaken in a formal and systematic manner *'it can assist health service organisations to manage adverse events compassionately and provide broader benefits through improved clinical communication and systems improvements'*. It emphasises that open disclosure is a dialogue between the affected party or parties and clinicians. It should not be viewed as a legal process or as indicating that *'an individual or service has blameworthy facts to disclose'*.

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[80] Australian Commission on Safety and Quality in Health Care, *Australian Open Disclosure Framework*, https://www.safetyandquality.gov.au/sites/default/files/migrated/Australian-Open-Disclosure-Framework-Feb-2014.pdf
[81] Australian Commission on Safety and Quality in Health Care, *NSQHS Standards*, Second Edition, Clinical Governance Standard, Patient safety and quality systems, Item 1.12, https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf

An open disclosure discussion may take place over several meetings and over an extended period. The framework also highlights that open disclosure will likely involve the ongoing provision of information, e.g. updates about how measures to address issues are being implemented.

The open disclosure framework outlines eight guiding principles for the process, namely:

- timely, open and honest communication about what went wrong
- acknowledgement of the adverse incident as soon as practicable
- provision of an apology or expression of regret as early as possible
- affected party or parties are fully informed of the facts surrounding the incident and its consequences, are treated with empathy and respect, and are supported in an appropriate manner
- health service staff are encouraged and able to recognise and report adverse incidents, are appropriately prepared to participate in open disclosure, and are supported through the open disclosure process
- integration of the incident management processes and open disclosure to ensure that any information obtained during open disclosure feeds back into quality improvement activities
- good governance frameworks
- management of patient and clinician confidentiality in accordance with relevant laws, balanced against the need for timely and open communication.[82]

It is clear from these principles that a major aspect of open disclosure is timeliness. This is reinforced by the Queensland Health *Best Practice Guide to Clinical Incident Management*, which notes that the initial discussion with the affected party or parties represents the beginning of open disclosure and assists to build trust and reassurance.[83] The lack of good governance frameworks in relation to identifying incidents meant that the opportunity to build trust and reassurance early through the open disclosure process was lost by the time Charlie's family were approached by the TCHHS. There are also key cultural considerations that must be considered when managing open disclosure with Aboriginal and Torres Strait Islander peoples.

9.3.3.2 Queensland Health guidelines for 'sad news, sorry business'

In December 2015, Queensland Health released the *'Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying'* (the guideline), which *'aims to provide insight into appropriate cultural knowledge and practices and identify tools that will assist Queensland Health staff in providing culturally and clinically responsive care for Aboriginal and Torres Strait Islander patients and their families'*[84] in relation to the planned and unplanned end stage of life.

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[82] ibid
[83] ibid
[84] Queensland Health, *Sad news, sorry business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying*, 2015, https://www.health.qld.gov.au/__data/assets/pdf_file/0023/151736/sorry_business.pdf

The guideline specifically differentiates between planned and unplanned death, noting that sudden or traumatic death may be viewed as sorcery or associated with blame and as such, special care needs to be taken to appropriately support the affected party or parties. The guideline suggests that for an unexpected death health services should[85]:

- anticipate that there could be strong reactions. Maintain respect and professionalism. It is important to appreciate and respect differences in perspective to avoid aggravating situations
- be honest and sincere when supporting the family
- coordinate care with the Aboriginal and Torres Strait Islander Hospital Liaison Officer or Health Worker
- practise good communication skills
- practise open disclosure sensitively and confidently.

In addition to the above, the guideline emphasises the importance of recognising the cultural diversity and distinct difference between Aboriginal and Torres Strait Islander peoples. They each have their own customary and sacred practices with a right to engage in their spiritual traditions and customs without discrimination or judgement.[86]

The guideline also sets out a number of considerations that may be relevant to planning for and engaging in open disclosure with Aboriginal and Torres Strait Islander peoples, including[87]:

- planning the open disclosure process with both the family and an appropriate person, which may be a senior in-law[88] in a Torres Strait Islander family. This planning should focus on identifying what will be shared, how and in what order
- recognising that person may have an ongoing role of offering constant support to the family and providing an explanation of the situation, provided they understand what is occurring (e.g. language or cultural barriers may prevent the required level of understanding)
- identifying any particularly emotional family members and explore and develop collaborative strategies to support families and avoid any potentially harmful situations
- inviting all required family members and ensuring that they are present for the discussion. Video or teleconferencing should be considered if not all members can be physically present
- planning the location to ensure that the environment affords sufficient privacy and comfort for the family. Alternative locations should be discussed if the health facility is not appropriate
- clarifying whether the deceased's name can be used and identifying what 'name' is suitable

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[85] ibid
[86] ibid
[87] ibid
[88] The family members to go to for advice on matters surrounding the passing of an Aboriginal or Torres Strait Islander person

- practising appropriate communication skills, giving the family time to understand what information is being shared. It is important that any persons involved with the open disclosure are truthful, genuine and confident
- explaining any post-mortem report and/or coronial or other processes that may be undertaken in relation to the passing.

9.3.3.3 TCHHS's approach to open disclosure

On 15 June 2018, Charlie's family were issued a letter from the TCHHS offering a clinical review meeting to discuss the findings from the May 2018 HEAPS analysis. The letter was the first formal approach by the hospital to the family following Charlie's passing, some 18 months earlier.

During this period, the TCHHS open disclosure policy and procedure was in draft. However, they advised the office that Bamaga Hospital follows the framework for open disclosure and it was their plan to offer the family a meeting following completion of the RCA. The TCHHS provided several open disclosure templates developed by the Clinical Excellence Division as evidence of their adherence with the open disclosure framework, including:

- Open Disclosure Organisational Readiness Assessment Tool '… *to assist Hospital and Health Services assess how well they meet the requirements for necessary structures and processes to be in place to implement open disclosure within the organisation, and to highlight areas where improvement would assist implementation'*
- Open Disclosure Team Response Planner
- Open Disclosure Meeting Checklist
- Open Disclosure Meeting Debrief.

The templates provided by TCHHS were developed by Clinical Excellence Division and should be considered a starting point for a HHS before adapting the template for their specific needs. None of the templates provided included any local considerations for either TCHHS broadly, or Bamaga Hospital specifically. The office was also not provided with a completed readiness assessment tool so it cannot comment on TCHHS's assessment of its capacity to undertake effective open disclosure.

The plan to offer open disclosure to Charlie's family was abandoned when the family advised our investigators that they would not consider any meeting with TCHHS.

The letter prepared by TCHHS to initiate communication with Charlie's family should have considered the principles of the open disclosure framework and the guidelines for *Sad News, Sorry Business*. Specifically there was:

- no offer of apology or condolences
- no explanation of an 'internal clinical review'
- no information about whether clinicians involved with Charlie's care would be attending the meeting
- no offer of coordination with the family about who should be invited and how that could be logistically managed

- no consultation with the family about the meeting schedule; this was dictated in the letter
- no 'cultural conduit' identified or offered to the family
- no consultation with the family about where the meeting could be held; it was mandated that it would occur at the hospital.

Charlie's case demonstrates missed opportunities impacting on the family's response to any open disclosure meeting, including:

- Bamaga Hospital did not provide Charlie's family information that would have helped them understand what happened to Charlie in a timely and open manner. As has been discussed elsewhere, Charlie's passing should have been identified much earlier as an incident, which should have then prompted an acknowledgement from Bamaga Hospital to the family and the open disclosure process should have commenced.
- Bamaga Hospital missed an opportunity to provide a formal apology or expression of regret to the family following Charlie's passing. Charlie's passing was sudden and traumatic for the family. A deep mistrust with Bamaga Hospital developed as a result of the inaction taken during and following Charlie's passing.
- Bamaga Hospital did not provide any ongoing support once Charlie and his family were outside of the TCHHS catchment. Charlie required high-level care and was transferred first to Cairns then Brisbane, where he passed away. His family were left to process his passing and navigate their way around a place far from their home and support. The family reported that the culture shock along with their grief was overwhelming; the lack of acknowledgement of this situation by Bamaga Hospital will remain with the family for some time.

Even setting aside the delay in identifying the link between Charlie's passing and the healthcare provided by Bamaga Hospital, when this connection was identified, none of the basic requirements towards an effective open disclosure process were met. The death of a child, particularly when it is unexpected, is an unimaginably tragic occurrence for the family and a sensitive, culturally appropriate, and meaningful open disclosure process is vital to enable the family to understand what has occurred. Overall, in Charlie's case, there was no partnering with the family to accommodate their needs in line with the open disclosure framework. Further, it was assumed that Charlie's family would understand the process and communication from TCHHS, but this was misguided. The lack of cultural sensitivity displayed by TCHHS and Bamaga Hospital's approach with Charlie's family is significant for a health service with a predominantly Aboriginal and Torres Strait Islander population.

Charlie's case demonstrates an inexperienced and culturally insensitive approach to open disclosure that highlights the need to embed an effective open disclosure policy and procedure. An open disclosure framework developed for TCHHS must also include how to deliver an appropriate culturally competent response to Aboriginal and Torres Strait Islander communities, recognising the cultural differences between these two populations. There is also a need for key TCHHS staff to undertake ongoing open disclosure scenario training to improve their ability to communicate with their consumers and understand their responsibilities to ensure the process they embark on builds rapport and trust. This should be supported by identifying people across TCHHS who are experienced in open disclosure and can offer support for any clinician in approaching open disclosure processes. Such an approach could include a

mandatory planning session between the clinician and the expert to ensure the open disclosure process is compliant, effective and culturally sensitive. This is particularly important when dealing with Aboriginal and Torres Strait Islander peoples and should be a key focus for Bamaga Hospital and TCHHS.

By approaching the family without any established rapport, Bamaga Hospital and TCHHS appear not to have considered cultural needs. Further, the approach caused the family distress and only strengthened their mistrust of the health service.

Overall, it appears Bamaga Hospital's safety and quality systems are not sufficiently developed to enable the service to respond to incidents via the clinical governance framework. They also appear to lack an understanding of the needs of Aboriginal and Torres Strait Islander communities as partners in clinical governance processes.

10. Recommendations

This office's investigation identified significant issues and areas for improvement, which have been discussed throughout this report. The recommendations made by this office will apply to both Bamaga Hospital as a facility and to TCHHS as the responsible HHS. The TCHHS will need to consider how it will direct, support and ensure Bamaga Hospital implements the measures detailed below (in partnership with the Bamaga community[89]) to address the issues discussed.

Clinical record keeping

Bamaga Hospital must maintain a high standard of clinical record keeping and ensure clinical staff are compliant with all record keeping policies and procedures. It is recommended that:

1. Bamaga Hospital includes in its *Best Practice Downtime Procedure* that downtime presentations must be recorded within four hours of the *Best Practice* system being restored in case of re-presentations or transfers.
2. The *Best Practice Downtime Procedure* specifies who is responsible for the entering of downtime forms, period of time to complete, and the process to be undertaken for locum and agency clinicians to ensure complete clinical record keeping.
3. Bamaga Hospital develops and undertakes a three-monthly audit to determine compliance with all documentation procedures and processes. Results from these audits should inform any corrective actions including further training.

Recognising deterioration

Bamaga Hospital must ensure clinical staff utilise the appropriate tools for recognising deterioration for all ED triaged patients. It is recommended that:

4. Bamaga Hospital identifies clinicians who have not completed their *Standard 8: Recognising and Responding to Acute Deterioration Standard* and ensures the mandatory training is completed as a matter of urgency.
5. TCHHS and the Clinical Educator increase the training frequency to an annual occurrence for use of the Early Warning Tools and the Sepsis Clinical Pathway.
6. Bamaga Hospital develops and undertakes a six-monthly audit to determine compliance with *Standard 8: Recognising and Responding to Acute Deterioration Standard*. Results from these audits should inform any corrective actions including further training.

[89] Reference to the 'Bamaga community' in these recommendations has been left deliberately broad. Identification of relevant community entities will need to be undertaken by Bamaga Hospital.

Communication and culture

Bamaga Hospital must ensure delivery of culturally competent care to its predominantly Aboriginal and Torres Strait Islander consumers. It is recommended that:

7. Bamaga Hospital, in collaboration with the Bamaga community, devises a strategy to communicate the Ryan's Rule patient escalation protocol in a culturally meaningful way to consumers.
8. A review of the Ryan's rule strategy and consumer understanding of the protocol should be conducted every six months until evidence of its ongoing efficacy can be established.
9. Bamaga Hospital, in collaboration with the Bamaga community, undertakes a review of the current role of the CLO servicing the region. The review should include an assessment of the overall awareness of the liaison service among consumers, the number of times the liaison service is utilised, and current hospital protocols for use of the liaison service following a clinical incident. Any potential improvements identified during this review process should be escalated to TCHHS for implementation as a matter of priority.

Model of care

Bamaga Hospital's ED operation must clearly fit within its service capability framework and aim to deliver a model of care that best suits the need of the community. It is recommended that:

10. Bamaga Hospital, in collaboration with the Bamaga community, develops and delivers a communication strategy to educate consumers on the respective roles and functions of the ED and the PHCC, and encourage utilisation of these services accordingly. Clinical staff should be included in this process and encouraged to contribute to the strategy.
11. A review of the efficacy of any education initiatives in regard to ED and PHCC roles should be undertaken at 12-monthly intervals.
12. Bamaga Hospital, in collaboration with TCHHS, continues to explore other model of care options, including the nurse practitioner model of care aimed at increasing consumer participation and consultation.

Resourcing and inducting clinical staff

Bamaga Hospital must ensure all clinical staff, including locums, are appropriately orientated and inducted to the facility. It is recommended that:

13. Bamaga Hospital identifies all clinical orientation documents, archives those that are outdated or inaccurate, and produces one clinical orientation document that complements TCHHS's guide and local induction process. The induction should incorporate safety and quality roles and responsibilities, cultural communication protocols of the region and how to deliver culturally competent care, as well as identify current health issues within the region.
14. Bamaga Hospital develops a plan/process for communicating health alerts issued by the TCHHS, Public Health and/or Queensland Health to ensure clinical staff are informed of all present health issues in the region.

15. Bamaga Hospital develops a plan/process that enables new staff, including locum clinical staff, to be orientated/inducted to the facility prior to commencement of duties. Evidence of induction should also be documented and recorded by the facility manager.
16. Bamaga Hospital develops and undertakes a six-monthly audit to determine compliance with orientation/induction procedures and processes. Results from these audits should inform any corrective actions including further training.
17. Bamaga Hospital reviews its current rostering arrangements to establish if improvements can be made to staffing allocations based on patient need and clinical skills. If potential improvements are identified they should be implemented as a matter of priority.

Clinical incident review

Bamaga Hospital and TCHHS must ensure clear and accountable clinical incident management processes. It is recommended that:

18. TCHHS revises its clinical incident governance framework to ensure it captures all serious clinical incidents, particularly for patients transferred to another HHS. This framework must include a terms of reference that provides role and responsibility clarity and a description of Bamaga Hospital's process in response to clinical incidents.

Open disclosure

Bamaga Hospital and TCHHS must ensure a culturally sensitive approach to open disclosure. It is recommended that:

19. TCHHS reviews its open disclosure policy and procedure to ensure it aligns with the *Australian Open Disclosure Framework*, and includes the open disclosure guidelines from *Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying*.
20. TCHHS convenes an open disclosure team that will become experienced at preparing for and delivering the process, as well as incorporating the culturally competent approach required for the region. The team should include an Aboriginal and/or Torres Strait Islander representative, who ideally has a relationship with the region. Open disclosure training should be arranged for the nominated persons.

11. Adverse comment phase

Under the *Health Ombudsman Act 2013*, an entity must be given an opportunity to comment on a draft investigation report where that report will make adverse comment and the entity is identifiable.[90] The response from the Health Service Chief Executive, TCHHS dated 29 June 2020 is attached in full at Appendix 4. TCHHS has accepted all recommendations.

Two practitioners provided submissions during the adverse comment phase. These submissions are captured in footnotes at the relevant sections of the report. One practitioner declined to provide submissions.

12. Conclusion

The changes needed at Bamaga Hospital to address the issues identified in this report are significant and improvement in these key areas will be challenging. This will require sustained effort and support from the highest levels of TCHHS through to individual practitioners working within the facility at any given time. This office is willing to work with Bamaga Hospital and TCHHS to support the implementation of the recommendations in this report.

Charlie's passing remains a deep loss felt by his family, friends and the small community of Bamaga. His story is one of a tragic confluence of events, leaving a family mistrusting of a health service that they have to continue to routinely access.

In the context of an examination of Charlie's care and treatment at the Bamaga Hospital, this investigation identified and analysed relevant systemic issues at the facility as well as actions considered necessary to improve its capability. This report's recommendations are aimed at encouraging Bamaga Hospital to address the gaps in the provision of emergency healthcare and approach to safety and quality governance, which impacted on Charlie's care.

[90] Section 86(3) of the *Health Ombudsman Act 2013*.

Abbreviations

AHPRA	Australian Health Practitioner Regulation Agency
APSGN	Acute poststreptococcal glomerulonephritis
ARF	Acute rheumatic fever
ATODS	Alcohol, tobacco and other drugs
ATS	Australasian Triage Scale
BC	Blood culture
BPF	Business Planning Framework
CEO	Chief Executive Officer
CEWT	Children's Early Warning Tool
CHHHS	Cairns and Hinterland Hospital and Health Service
CLO	Consumer Liaison Officer
CRP	C-reactive protein
CSCF	Clinical Services Capability Framework
ECMO	Extracorporeal membrane oxygenation
ED	Emergency department
EDIS	Emergency Department Information System
EWT	Early Warning Tools
GP	General Practitioner
HBCIS	Hospital Based Corporate Information System
HEAPS	Human Error and Patient Safety
HHSs	Hospital and Health Services
HITH	Hospital in the Home
ICU	Intensive Care Unit
IHS	Integrated Health Service
ILO	Indigenous Liaison Officer
LCCH	Lady Cilento Children's Hospital; now Queensland Children's Hospital
LMO	Locum medical officer
MPHS	Multipurpose Health Service
NGO	Non-government organisation

NP	Nurse Practitioner
NPA	Northern Peninsula Area
NSQHS	National Safety and Quality Health Service Standards
PCCM	Primary Clinical Care Manual
PHCC	Primary Health Care Centre
PICU	Paediatric Intensive Care Unit
QBA	Queensland Bedside Audit
Qld	Queensland
QSRU	Quality, Safety and Risk Unit
RCA	Root Cause Analysis
RESIST	Recognise Early Signs Initiate Sepsis Treatment program
RFDS	Royal Flying Doctor Service
RRCSU	Rural and Remote Clinical Support Unit
RSQ	Retrieval Services Queensland
SAC	Severity assessment code
SMO	Senior medical officer
STD	Sexually transmitted disease
SToRK	Simulation Training on Resuscitation for Kids program
TCHHS	Torres and Cape Hospital and Health Service
TPHS	Tropical Public Health Service

Appendix 1 Charlie's clinical chronology

Table 1 Clinical chronology of Charlie Gowa's care and management between 9 and 14 January 2017

Time	Health Service Provider Records	Event
Monday 9 January 2017		
2.22pm	Bamaga Hospital	▪ Triaged as a category 4 patient with vomiting since 5 and 6 January, followed by diarrhoea.
2.26pm	Bamaga Hospital	▪ Vital signs recorded: Temp: 39.8 degrees Celsius Pulse: 125 beats per minute Oxygen Saturation: 100% Respiratory Rate: 28 per minute Weight: 19.10 Kgs. ▪ Blood pressure is not recorded.
2.41pm	Bamaga Hospital	▪ Charlie's history recorded including he had been unwell since the previous Thursday and there was '*gastro in community currently*'. ▪ Charlie was examined and recorded to have a viral gastroenteritis.

Time	Health Service Provider Records	Event
		▪ The management plan included a fluid challenge, paracetamol, to check urine analysis and blood pressure with review in one hour. ▪ His medication chart notes he is given ondansetron, paracetamol, and Nurofen at the hospital, and paracetamol to take home.
Tuesday 10 January 2017		
2.00pm	Bamaga Hospital	▪ Triaged as a category 4 patient with pain, representation 1/7 with increasing pain in his head, febrile and lethargic. ▪ Vital signs are noted and he is given ondansetron, Panadol, and a urine sample is requested.
3.16pm	Bamaga Hospital	▪ Urine sample result receipt.
3.41pm	Bamaga Hospital	▪ Doctor recorded Charlie had been unwell since the previous Thursday (5 January 2017) and had presented on the Saturday with two days vomiting and diarrhoea; and from Sunday afternoon with fever, headache and lethargy, but no rash or skin infection. He did have a high temperature and complained of nausea. ▪ Doctor's assessment queried a viral illness with a management plan to provide Charlie with ondansetron, paracetamol, ibuprofen, and encourage oral fluids.
4.00pm	Bamaga Hospital	▪ An ECG was arranged and a CEWT (for tertiary and secondary facilities) was commenced. ▪ The total CEWT score was three; however, Charlie's oxygen saturation level was not recorded.

Time	Health Service Provider Records	Event
4.20pm	Bamaga Hospital	▪ Doctor recorded Charlie's progress as drowsy, febrile with a reduced temperature, and complaint of headache. ▪ The management plan recorded that Charlie was to be admitted to the ward with intravenous cannulation and fluids, bloods to be taken, repeat urine analysis, and observations to occur every two hours.
4.30pm	Bamaga Hospital	▪ Observations are recorded with the total CEWT score noted as five. This score prompts medical review within 30 minutes.
5.00pm	Bamaga Hospital	▪ CEWT observations are undertaken with no total score recorded and primary survey incomplete. ▪ A triage category of 3 and blood glucose level (BGL) of 8.2mmol is recorded. The presenting problem is noted as '*Headache and lethargy post gastro like symptoms. Has not had symptoms 3/7. Still nausea.*'
5.50pm	Bamaga Hospital	▪ CEWT observations are recorded but no total score completed.
6.11pm	Bamaga Hospital	▪ An admission letter from doctor to the senior nurse is recorded detailing Charlie's history, examination, assessment, medication management, and ECG results. The doctor requested to be advised of any concerns or fever, and intravenous ceftriaxone and paediatrician consult are queried.
≈ 6.30pm	Bamaga Hospital	▪ A referral letter from doctor to the paediatric registrar at Cairns Hospital details the above information including their discussion for Charlie to be transferred to Cairns Hospital and to commence intravenous ceftriaxone 50mg/kg (950mg) stat.

Time	Health Service Provider Records	Event
6.35pm	Bamaga Hospital	▪ The RSQ Clinical Coordination Form details Charlie's clinical situation using ISBAR.[91] No CEWT score is recorded, patient severity is ticked as 'low dependency', patient priority of '3' (Urgent 3-6hrs) is indicated, and recorded the referring and receiving facility details for the transfer as Cairns Hospital.
6.50pm	Bamaga Hospital	▪ Ceftriaxone is commenced.
7.00pm	Bamaga Hospital	▪ The CEWT 'Interventions and clinical comments' section noted Charlie's earlier medications, cannulations, and temperature. It also noted tests for bloods, throat swab, and urine analysis had been taken, as well as the commencement of ceftriaxone. Charlie had been '*prepped for transfer to Cairns. Awaiting time for pick up'.*
	RFDS	▪ Request to transfer Charlie to Cairns, the observations recorded are not from CEWT, his diagnosis is recorded as *'headache'*, and he is given a Flight Priority of 4 (retrieval between 6 and 24hours).
8.00pm	Bamaga Hospital	▪ CEWT observations are recorded without a total score. It is further noted they are still waiting for the time of transfer.
Wednesday 11 January 2017		
12.30am	Bamaga Hospital	▪ Set of CEWT observations resulted in a total score of four indicating review by a doctor or nurse practitioner within 30 minutes.

[91] ISBAR - Identify, Situation, Background, Assessment and Recommendation is a mnemonic created to improve safety in the transfer of critical information.

Time	Health Service Provider Records	Event
		▪ A **retrospective nursing note** recorded in the Progress Notes of Charlie's medical record at 6.35am documents Charlie is in '*severe pain in bilateral knees, head and abdo pain*'. His temperature was 39.5 degrees, respiratory rate (RR) 34, pulse 142 with paracetamol and ibuprofen administered. The nurse documented she had phoned locum doctor and RFDS doctor.
12.50am	Bamaga Hospital	▪ Doctor reviewed Charlie and recorded he was very distressed and crying. He had not passed urine since 5pm the previous day and a bladder scan indicated it was full.
1.00am and 1.17am	RSQ	▪ Charlie's vitals recorded and it is suggested Charlie's current condition to be discussed with the Cairns paediatric registrar. ▪ Charlie was able to pass urine after his pain decreased and he continued to tolerate oral fluids.
1.36am	Bamaga Hospital	▪ Doctor documented she has been called to review Charlie. She noted his temperature at 39.5 degrees, pulse 142, blood pressure 90/60, RR 32, oxygen saturation level on room air 99%. Charlie was complaining of thirst, abdominal pain, knee pain, and headache. On examination Charlie was alert, very distressed but cooperative. ▪ A viral illness was still considered at this time; however, following discussions with RSQ and the Cairns paediatric registrar, it was recorded to continue with the management plan with no further investigations required at that time.
1.50am	Bamaga Hospital	▪ CEWT observations were recorded with a total score of one. Nursing notes documented Charlie had settled by 2am but '*slept intermittently overnight*'.

Time	Health Service Provider Records	Event
3.00am	Bamaga Hospital	▪ CEWT total score was recorded as one; however, level of consciousness was not recorded at the time, only a notation of '*asleep*'.
4.00am	RSQ	▪ RSQ were contacted by Bamaga Hospital, advising Charlie was '*comfortable and asleep*'. Locum doctor was noted to have gone home and no further orders from the Cairns paediatric registrar had been advised.
4.30am	Bamaga Hospital	▪ CEWT score of zero was recorded.
5.00am	RSQ	▪ Charlie's CEWT score remained at 1, he'd passed urine but the volume was unknown, no respiratory distress but he looked unwell, lethargic, and miserable.
5.27am	RSQ	▪ Charlie's vitals recorded, a CEWT score of zero, and that he was asleep waiting for transfer.
6.05am	Bamaga Hospital	▪ A total CEWT score of one is recorded and nursing notes documented locum doctor was informed of Charlie's low BP and his intravenous fluids were increased.
8.15am	Bamaga Hospital	▪ A new CEWT 'rural and remote facility' form was commenced with a total score of zero recorded.
8.30am	Bamaga Hospital	▪ Locum doctor reviewed Charlie documenting that Charlie had developed arthralgia overnight, ongoing headache and abdominal pain, and his urinary output had decreased but he had passed urine earlier that morning. ▪ On examination Charlie was '*grizzly wanting to sleep, not wanting to be disturbed*'.

Time	Health Service Provider Records	Event
		▪ The plan was to continue intravenous therapy at maintenance, monitor urine output and complete a chest x-ray. She questioned '*expect RFDS*' at 10.30am.
9.00am	Bamaga Hospital	▪ Locum doctor noted her discussion with RSQ and the Cairns paediatric registrar. It was recorded no further antibiotics or antiviral treatment to be considered at the time and to await the chest x-ray.
9.40am	Bamaga Hospital	▪ Locum doctor recorded her review of Charlie's chest x-ray resulting in *'diffuse and patchy consolidation'* in the right lower lung.
9.47am	Bamaga Hospital	▪ In consultation with the Cairns paediatric registrar, oral azithromycin was commenced.
10.19am	Bamaga Hospital	▪ RSQ documented locum doctor had phoned and advised Charlie had a chest x-ray resulting in right lower lung pneumonia; on examination posterior crackles, haemodynamically stable, CEWT of zero, and was being treated with azithromycin.
10.32am	Bamaga Hospital	▪ Queensland Ambulance Service (QAS) had arrived to transfer Charlie to the airport for retrieval.
11.00am	Bamaga Hospital	▪ Final CEWT observations were incomplete.
11.46am	RFDS	▪ Retrieved and transferred Charlie to Cairns Hospital. ▪ The RFDS medical officer advised Charlie's BP dropped inflight but responded well to a fluid bolus. No other inflight events were recorded.
1.37pm	Cairns Hospital	▪ Charlie is triaged on arrival.

Time	Health Service Provider Records	Event
2.22pm	Cairns Hospital	▪ Charlie is clinically assessed.
3.19pm	Cairns Hospital	▪ Admitted and transferred to the paediatric unit where the impression recorded included pneumonia; and queried ruptured appendicitis, urinary retention, and meningitis. He continued to be treated with antibiotics, ceftriaxone and azithromycin; and pain medication including fentanyl and endone for his severe headache. ▪ Charlie remained under close observation while he underwent relevant investigations; however, significantly deteriorated with his CEWT total scores increasing throughout the afternoon.
10.00pm	Cairns Hospital	▪ Pathology blood culture results recorded a positive notifiable condition of gram negative bacillus which had been isolated or a confirmatory test had been ordered.[92]
10.12pm	Cairns Hospital	▪ Charlie's total CEWT score was a 7 prompting an immediate review. The impression recorded was sepsis with the ICU registrar contacted to review with a plan to admit for escalation of care.
Thursday 12 January 2017		
?am	Cairns Hospital	▪ Charlie is transferred to Intensive Care Unit (ICU).
3.15am	Cairns Hospital	▪ Charlie had a diagnosis of septic shock of unknown source and was intubated. ▪ His antibiotic treatment included meropenem, vancomycin, and azithromycin.

[92] Growth of the bacteria is required to diagnose melioidosis.

Time	Health Service Provider Records	Event
		▪ Charlie was continuously reviewed by the ICU specialist in consultation with the Townville Paediatric Intensive Care Unit (PICU).
10.13am	Cairns Hospital	▪ An initial plan to retrieve and transfer Charlie to LCCH for ECMO support was discussed with RSQ. A plane was not available at the time and it was noted Charlie would be transferred to Townsville Hospital PICU instead.
	Cairns Hospital	▪ Charlie continued to deteriorate and further discussions with RSQ and LCCH lead to the ECMO retrieval team being mobilised with an estimated time of arrival of 6pm. Charlie continued to be managed with the assistance of the RFDS and Townsville Hospital PICU retrieval team. ▪ Prior to Charlie's retrieval, documentation noted Charlie's father was made aware that Charlie was at risk of dying and may not survive until the ECMO team arrived.
6.00pm	Cairns Hospital	▪ The Brisbane retrieval team arrived and commenced ECMO cannulation in preparation for air transfer to LCCH.
Friday 13 January 2017		
12.10am	Cairns Hospital	▪ Charlie is transferred to LCCH, Brisbane.
5.25am	LCCH	▪ Charlie was admitted to PICU for management of gram negative sepsis. ▪ He continued intensive antibiotic therapy of meropenem, vancomycin, lincomycin and erythromycin; in addition to intensivist care.

Time	Health Service Provider Records	Event
12.35pm	LCCH	▪ Progress notes from infectious diseases reports chasing the identity of the positive BC but covering for melioidosis, and changing antibiotic coverage from erythromycin to azithromycin.
7.39pm	LCCH	▪ Further discussions about melioidosis and antibiotics were noted between the PICU intensivist and infectious diseases.
11.04pm	LCCH	▪ A note by the PICU intensivist documented Charlie had severe melioidosis and had discussed the situation with Charlie's parents explaining recent computed tomography (CT) findings were suggestive of brain damage with his chances of dying high despite full clinical support.
Saturday 14 January 2017		
	LCCH	▪ Throughout the day, discussions with Charlie's family about his condition were noted.
6.15pm	LCCH	▪ Charlie's family decided to withdraw treatment and Charlie was extubated.
6.48pm	LCCH	▪ Charlie's death is recorded as a result of melioidosis sepsis.

Appendix 2 List of investigation documents

A copy of the full list of documents obtained and relied upon to inform this investigation can be found on the office's website.

Appendix 3 National and statewide frameworks and guidelines

National and state standards, frameworks and guidelines

National Strategic Framework for Rural and Remote Health

The National Strategic Framework for Rural and Remote Health promotes a national approach to policy, planning, design and delivery of health services in rural and remote communities.

The Framework has been developed through the Australian Health Ministers' Advisory Council's (AHMAC) Rural Health Standing Committee (RHSC)[93] with the valued input of the National Rural Health Alliance and a wide range of other rural health stakeholders.

The Framework is directed at decision and policy makers at the national, state and territory levels. It emphasises the need for health and prevention services, programs, workforce and supporting infrastructure designed to meet the unique characteristics, needs, strengths and challenges experienced in rural and remote parts of the country.

By providing this direction and identifying the systemic issues that most require attention, the Framework aims to improve health outcomes and return on investment for rural and remote Australians.

While primarily a tool for government, the Framework may also be useful to communities, local health service providers and community groups to help identify and develop new and innovative ways to address specific needs or unique characteristics of their local area or region.

The Framework is designed to encompass the full range of health-related services provided in rural and remote settings. This includes prevention and screening, early intervention, treatment and aged care services, and the delivery of specific health services including primary health care, hospital and emergency care, mental health, dental health, maternity health and preventative health.

It also recognises the needs of specific population groups, including older people, babies and children, Aboriginal and Torres Strait Islander peoples, people with chronic disease, refugees and people from culturally and linguistically diverse backgrounds.

Business Planning Framework: a tool for Nursing and Midwifery workload management 5th Edition, Emergency Department Addendum 2018

The ED addendum is the industrially mandated tool to support business planning for the purpose of managing nursing and midwifery resources and workloads in public sector health facilities. The principles of the BPF 5th Edition apply to all remote, rural, regional and metropolitan nursing and midwifery

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[93] RHSC is a standing committee established under the Australian Health Ministers' Advisory Council (AHMAC) to provide advice on, and to progress, national issues relevant to improving health services in rural and remote Australia. Membership of the RHSC comprises the Australian Government and the governments of all States, the Northern Territory, and New Zealand.

services in Queensland Health. This addendum is designed to recognise the unique challenges for nurses working in EDs and must be used in conjunction with the BPF 5th Edition.

The National Safety and Quality Health Service (NSQHS) Standards

The Australian Commission on Safety and Quality in Health Care (the Commission) was established in 2006 by the Australian, state and territory governments to lead and coordinate national improvements in safety and quality in health care.[94] One of the Commission's key outputs was the introduction of the National Safety and Quality Health Service Standards (the National Standards), which were introduced in September 2011. All health service organisations were required to be accredited to the National Standards from January 2013.

A second edition of the National Standards was released in November 2017. All health service organisations commenced being accredited against these new standards from January 2019. The second edition was developed in consultation with a wide variety of stakeholders with a view to *'address[ing] gaps identified in the first edition, including mental health and cognitive impairment, health literacy, end-of-life care, and Aboriginal and Torres Strait Islander health. [The second edition] also updates the evidence for actions, consolidates and streamlines standards and actions to make them clearer and easier to implement, and reduces duplication'.*[95]

Under the second edition, the 'Clinical Governance' and 'Partnering with Consumers' standards create the *'overarching system requirements for the effective implementation of the remaining six standards, which deal with specific high-risk clinical areas of patient care'*.[96] This overarching system is further supported by the National Model Clinical Governance Framework, which *'provides a consistent national framework for clinical governance that is based on the [standards and] … supports a shared understanding of clinical governance among everyone working in health service organisations, including clinicians, managers and members of the governing body. This will ensure that clinical governance systems are implemented effectively, and support safer and better care for patients and consumers'*.[97]

The eight National Standards are:

1. clinical governance
2. partnering with consumers

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[94] Australian Commission on Safety and Quality in Health Care, '*About Us*', https://www.safetyandquality.gov.au/about-us/governance/

[95] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards Second Edition Overview*, https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/Overview-of-the-NSQHS-Standards-second-edition.pdf

[96] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards guide for hospitals*, Sydney, 2017, https://www.safetyandquality.gov.au/sites/default/files/2019-05/national-safety-and-quality-health-service-standards-guide-for-hospitals.pdf

[97] Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework*, Sydney, 2017, https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf

3. preventing and controlling health care associated infections
4. medication safety
5. comprehensive care
6. communicating for safety
7. blood management
8. recognising and responding to acute deterioration.[98]

Under the second edition all health service organisations will be required to be accredited against the eight National Standards every three years, with no mid-cycle review. This is a change from the first edition where accreditation happened every three or four years with a mid-cycle review of some specific standards. Transitional arrangements for health service organisations on the four-year cycle ceased on 31 December 2019.[99] Health service organisations now have to achieve re-accreditation before their accreditation award expires; this is likely to be some four months before the end of the three-year accreditation period.[100]

To achieve accreditation a health service organisation is assessed against each standard, which has four specific criteria and a number of associated actions relevant to each criteria. Assessors will be evaluating whether the health service organisation has met the actions required in the standard. Accreditation can now be undertaken via two pathways: announced or short notice assessments.[101] The short notice assessments are a new approach and involve three or four standards being assessed during each visit, for which 48 hours' notice is given to the health service organisation.[102] During an accreditation cycle there will be three short form assessments, with no more than two per year. Some standards may be assessed more than once in the accreditation cycle so that a health service organisation is not aware of what standard is being assessed.[103]

A health service organisation can achieve accreditation where the actions are either met or met with recommendations, provided that it is the first occasion on which an action is being met with recommendations.[104] If a hospital does not meet some of the actions then they are given 60 business

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[98] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards, 2nd ed*, Sydney, 2017, https://www.safetyandquality.gov.au/sites/default/files/2019-04/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf

[99] Australian Commission on Safety and Quality in Health Care, *Fact Sheet 2: Transition Arrangements for Assessments in 2019*, updated October 2018, https://www.safetyandquality.gov.au/sites/default/files/2019-05/fact_sheet_02_transition_arrangements_for_assessments_in_2019.pdf

[100] ibid

[101] ibid

[102] ibid

[103] ibid

[104] ibid

days to rectify the issue/s before a decision is made regarding accreditation.[105] If the final assessment still determines that there are criteria not met, then the hospital may be reassessed in six months.[106] After a reassessment if a health service organisation still has actions that are not met then their accreditation will be rescinded and they will have to work with the Commission to achieve future accreditation.[107]

The Commission has approved accrediting agencies to accredit hospitals in accordance with the National Standards. The oversight of the assessors has been strengthened and enhanced under the processes for the second edition, including post-assessment surveys, observation visits, data analysis and information from regulators.[108]

The second edition of the National Standards has considerable changes and seeks to ensure a more dynamic and comprehensive approach to accreditation to protect the public from harm and improve the quality of health service provision across Australia.

NSQHS User Guide for Aboriginal and Torres Strait Islander Health

The Australian Commission on Safety and Quality in Health Care (the Commission) plays an important role in ensuring that the wide range of health service organisations across Australia provide safe and high-quality health care. As good as the Australian health care system is at responding to the health care needs of the majority of Australians, Aboriginal and Torres Strait Islander peoples remain disadvantaged in accessing health services and experience significantly disparate health outcomes.

For this reason, the Commission has, for the first time, defined six actions that specifically meet the needs of Aboriginal and Torres Strait Islander peoples within the National Safety and Quality Health Service Standards:

1. working in partnership
2. addressing health needs to Aboriginal and Torres Strait Islander peoples
3. implementing and monitoring targeted strategies
4. improving cultural competence
5. creating a welcoming environment
6. identifying people of Aboriginal and Torres Strait Islander origin.

These actions were defined following a comprehensive consultation process. Their implementation will help orientate the health system to provide all Aboriginal and Torres Strait Islander peoples with the healthcare they need. This could reduce the gap in health outcomes between Aboriginal and Torres Strait Islander peoples and other Australians. The guide provides practical strategies for what to consider

[105] ibid
[106] ibid
[107] ibid
[108] ibid

and how to bring the six actions to life in any health service organisation. It also provides practical examples from across Australia that demonstrate that these actions can be, and are being, implemented in health service organisations.

Six guides have been produced to assist health service organisations improve care for Aboriginal and Torres Strait Islander consumers. They are linked to the NSQHS Standards and have also been aligned to the Aboriginal and Torres Strait Islander people-specific actions in version 2 of the NSQHS Standards.

Clinical Services Capability Framework

In 1994, the first iteration of the Clinical Services Capability Framework for public and licensed private health facilities (CSCF) was introduced in Queensland. It originally only applied to public hospitals but from 2004 it was extended to apply to private hospitals. The CSCF sets out the clinical and support services that a hospital can safely provide within their capability level.

There are six CSCF levels for facilities indicating their complexity of care from a low to high range level of service including:

- Level 1: Low complex ambulatory care service
- Level 2: Low complex inpatient and ambulatory care service
- Level 3: Low to moderate complex inpatient and ambulatory care service
- Level 4: Moderate complex inpatient and ambulatory care service
- Level 5: Moderate to high complex inpatient and ambulatory care service
- Level 6: High complex inpatient and ambulatory care service.

As a general rule, service levels build on previous service level capability (one exception is adult emergency services). For instance, a service nominated as having level 6 capability should have all the capabilities of clinical services up to level 5 plus additional capabilities resourcing the most highly complex clinical service. Each service level provides the additional capabilities representing the minimum requirements for that level.

The children’s medical services module includes many specialties and requires significant support services to provide safe patient care. These services are provided by registered medical practitioners and/or a range of registered medical specialists, nursing and allied health professionals (with adequate support services) in addition to multidisciplinary teams. Additionally, a small number of patients may require super-specialist services for complex clinical issues.

All existing and new CSCF module development is managed via the CSCF Governance Committee, which is overseen by the Chief Health Officer, Department of Health, and the Director General, Department of Health.

Primary Clinical Care Manual

The PCCM is the principal clinical reference and policy document for health professionals working in diverse and rural and remote health service settings and contains clinical guidelines and Health Management Protocols.

The PCCM supports and enables rural, remote and isolated clinicians to provide the best possible evidence based and safe care for the people living in these areas. It has been developed and reviewed according to the principles set out by the National Health and Medical Research Council in Queensland. The PCCM meets legislative requirements to support the expanded practice of clinicians who have undergone additional education and have additional authorities to administer and supply medicines, including:

- rural and isolated practice registered nurses
- sexual health program registered nurses
- immunisation program nurses
- midwives
- Aboriginal and Torres Strait Islander health practitioners
- authorised Indigenous health workers
- Queensland Ambulance Service – Isolated Practice Area Paramedics.

Queensland Health Best Practice Guide to Clinical Management

The aim of clinical incident management is to effectively manage clinical incidents with a view to reducing preventable patient harm. Clinical incident management is an essential component of quality patient care. This is achieved through processes that:

- identify and treat hazards before they lead to patient harm (pro-active)
- identify when patients are harmed and promptly intervene to minimise the harm caused to a patient as a result of the incident (reactive)
- disclose a clinical incident resulting in patient harm (pro-active and reactive)
- ensure that lessons learned from clinical incidents are communicated and applied by taking preventive actions designed to minimise the risk of similar incidents occurring in the future (pro-active and reactive).

From 1 July 2013, Hospital and Health Services (HHSs) were accountable for local decision making about how to best manage and respond to patient safety incidents occurring in their health service area. Implementing systems to ensure that patient safety incidents are recognised, reported and analysed and information used to improve safety systems is a mandatory requirement of NSQHS Standards for accreditation.

The guide is a resource to help support individual and organisational learning and to drive quality improvement, in response to patient safety incidents. Organisations may also choose to use the guide to support quality assurance processes. The guide is not mandatory but provides a framework and practical tools that may be adopted or adapted to suit local circumstances and needs.

Queensland Health Aboriginal and Torres Strait Islander Patient Care Guideline

The guideline is designed as a quick reference tool to support healthcare staff in delivering inpatient care to Aboriginal and Torres Strait Islander patients. It provides general advice only and does not address the diverse cultural differences across Australia. The guideline discusses three sections including:

- factors influencing access to healthcare
  - cultural factors
  - social and historical factors
  - accessing services from remote locations
- providing culturally capable patient care
  - culturally appropriate communication
  - gathering information
  - the hospital experience
- aspects of clinical care
  - medical examinations
  - diagnosis and treatment
  - administration of medication
  - pain medication
  - patient discharge
  - end of life care
  - other healthcare support.

Sad News, Sorry Business – Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying

The guideline was first published in 2011, aiming to provide insight into appropriate cultural knowledge and practices and identify tools that will assist Queensland Health staff in providing culturally and clinically responsive care for Aboriginal and Torres Strait Islander patients and their families through this significant stage of life.

In 2014, Queensland Health published the Aboriginal and Torres Strait Islander Patient Care Guideline which provides general information with respect to providing healthcare for Aboriginal and Torres Strait Islander peoples.

In Version 2 of Sad News, Sorry Business, duplication of content which is now available in the patient care guideline has been avoided. It is therefore highly recommended that the patient care guideline be read as a preliminary to Sad News, Sorry Business. Version 2 also includes additional advice, in particular for the time following a person's passing.

The guideline is comprised of three sections including:

- Aboriginal and Torres Strait Islander cultural capability
  - cultural respect and recognition
  - communication
  - relationships and partnerships
  - capacity building
- The final stages of life
  - before the passing
  - time of passing
  - traumatic or sudden death
- Time after passing
  - sad news, sorry business
  - open disclosure
  - coronial investigations.

Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033

The scope of the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033 is clearly focused on the provision of culturally appropriate health services to Aboriginal and Torres Strait Islander consumers and communities. The Framework, while fully acknowledging the distinct requirements of many other culturally diverse peoples, excludes generic cultural capabilities in relation to culturally and linguistically diverse consumers and communities, which are addressed in the Queensland Health Organisational Cultural Competency Framework.[109]

In the framework, *'cultural capabilities'* refer to the *'skills, knowledge and behaviours that are required to plan, support, improve and deliver services in a culturally respectful and appropriate manner'*.

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[109] Queensland Health Strategic Plan for Multicultural Health 2007–2012, Implementation Plan 2009-2010, Brisbane

The framework is to guide every aspect of health service delivery for and with Aboriginal and Torres Strait Islander Queenslanders. The framework is based on the Australian Health Ministers' Advisory Council (AHMAC) endorsed Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009 that was developed as a guiding principle in policy construction and service delivery to strengthen relationships between the healthcare system and Aboriginal and Torres Strait Islander peoples.

The purpose of the framework is to provide overarching principles for the governance, policy, planning, infrastructure, information systems, human resource management, quality improvement, education and training, and every aspect of culturally capable health service delivery; and to guide the skills, knowledge and behaviours that are essential for all levels of Queensland Health employees to provide culturally appropriate health services for Aboriginal and Torres Strait Islander Queenslanders.

Appendix 4 TCHHS response to report

Torres and Cape Hospital and Health Service

Enquiries to: Office of the Chief Executive
Cairns:
Cooktown: [redacted]

29th June 2020

Andrew Brown
Health Ombudsman
PO Box 13281
George street
Brisbane QLD 4003

Subject: Health Services provided by Bamaga Hospital

I write to you in regard to *The Review into the Quality of Health Services Provided by Bamaga Hospital, a systematic investigation.*

Torres and Cape Hospital and Health Service (TCHHS) respectfully acknowledge the loss of Charles Gowa and recognise the distress and anguish of his parents and extended family.

TCHHS has undertaken two reviews of the care provided to Charlie and has now also considered the information provided in your Office's review.

Charlie's story as told by his Mother is distressing to read and we recognise the pain and frustration felt by family. We note the Ombudsman's finding that the likelihood is that Charlie was bought to the Hospital prior to the first recorded visit on January 9TH.

TCHHS do not believe that challenging or addressing details in this report is constructive or appropriate, given the time lapsed since Charlie's passing. TCHHS prefers to work with the Office, family and stakeholders to reassure Community of the standard of care delivered at Bamaga Hospital.

I understand that [redacted], Executive General Manager, TCHHS, has been liaising with your office regarding the report and recommendations.

TCHHS accepts the recommendations with the clarifications agreed and the action plan term. We will work with your office on the implementation and monitoring of the recommendations.

TCHHS has made further approaches to the family and have offered to undertake open disclosure and/or family meetings. The family spokesperson has indicated that family wish to consider the Ombudsman's report before any meeting.

Executive Office
Torres and Cape Hospital and Health Service
[redacted]

Contact Details
[redacted]
Email: [redacted]
Web: health.qld.gov.au/torres-cape

Postal Address
[redacted]

Family, community and staff have been affected by these tragic events, TCHHS requests that the public release be managed to allow assurances of safety to be made and consumer concerns to be addressed.

Please be assured that Bamaga Hospital Services have developed significantly since 2017 including:

- We now have four permanent medical officers in the NPA offering seven day per week services (previously two locum medical officers)
- We have regular programmed visits by our Consumer Liaison Officer.
- Training and auditing of Standard Eight is undertaken regularly.
- Bamaga Hospital has a functioning multiagency Health Action Team (HAT).
- Public Health alerts have appropriate governance within the HHS.
- Our open disclosure and clinic governance frameworks have been reviewed within the last 12 months.
- The clinical medical record system used across the Torres and NPA is more functional.
- The medical staff in Bamaga and Thursday Island are more integrated in their education and clinical handover systems.

Torres and Cape HHS commits to working with the OHO in relation to the recommendations to provide assurance to the communities within our region; in the light of being fully participative in any future review can we suggest the inclusions of an independent Rural and Remote Generalist, this may prove a beneficial addition.

Regards

Beverley Hamerton

Health Service Chief Executive

Torres and Cape Hospital and Health Service