CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Austin Facer
Hearing dates:	29 August – 5 September 2022
Date of findings:	8 December 2022
Place of findings:	NSW Coroner Court - Lidcombe
Findings of:	Deputy State Coroner Elizabeth Ryan
Catchwords:	CORONIAL LAW – death of child at Broken Hill Base Hospital – can cause of death be ascertained – was medical care and treatment adequate – were transfer decisions managed appropriately – recommendations.
File number:	2019/0330336

Representation:	Counsel Assisting the Inquest: P Aitken of Counsel i/b D Lekakis of Department of Communities and Justice, Legal. The Facer family: S Grey of Counsel i/b Y Bagrin, Slater and Gordon Lawyers Dr H Ravindranathan: K Kumar of Counsel i/b MDA National Far West Local Health District, Newborn and Paediatric Emergency Transport Service [NETS], NSW Ambulance and Sydney Children's Hospitals Network [SCHN]: L Boyd of Counsel i/b H Allison, NSW Crown Solicitor Dr T Bailey and Dr M Kummerow: M Hutchings of Counsel i/b J Hayes, Meridian Lawyers MedSTAR and Dr P Lambert: B Garnaut of Counsel i/b South Australian Crown Solicitor Dr F Mitchell: R Rodger of Counsel i/b E Marel, Avant Law
Findings:	**Identity of deceased** The person who died is Austin Facer. **Date of death** Austin Facer died on 22 October 2019. **Place of death** Austin Facer died at Broken Hill Base Hospital. **Cause of death** Austin Facer died as a result of cardiopulmonary arrest on a background of earlier cardiac arrests and resuscitations. **Manner of death** The manner of Austin Facer's death is natural causes.

Recommendations:	**Recommendation 1** To the SCHN, NETS, MedSTAR, the Women's and Children's Hospital Adelaide and the Far West Local Health District: A. In relation to urgent/critically ill paediatric patient retrieval from Broken Hill Base Hospital to WCHA, that a mutually agreed Guideline be settled between the parties as soon as possible, covering operational and clinical processes for paediatric patient retrieval, including clinical consultation, logistics, bed availability and communication requirements. B. That the Guideline acknowledge the responsibility of NETS to remain involved and informed in the retrieval process, including up to the point where the relevant MedSTAR retrieval team collects the patient from Broken Hill Base Hospital. **Recommendation 2** To NETS and SCHN: That work continue on developing a secure method for exchanging a patient's clinical information (including relevant imaging and traces) with involved receiving clinicians, consulting clinicians, and MedSTAR, through the E-referral form and any other appropriate mechanism. **Recommendation 3** To SCHN, NETS and the Far West Local Health District: That the 'Model of Care for Paediatric Patients in Far West LHD' continues to be revised, including to incorporate guidance on the responsibilities and role of NETS medical and nurse consultants and any other matters of concern.

Introduction

1. Section 81(1) of the *Coroners Act 2009* (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

2. These are the findings of an inquest into the death of Austin Facer.

3. Austin Facer was only six years old when he died in the early hours of 22 October 2019.

4. The previous day Austin had suffered a cardiac arrest at his primary school in Broken Hill. School staff and paramedics managed to revive him, and he was taken to Broken Hill Base Hospital. But although his condition stabilised it remained very serious, and by the early afternoon his treating team were agreed that he needed transfer to a hospital which could provide a higher level of care.

5. Many hours passed before a medical retrieval team arrived at Broken Hill at 11.30pm that night. Shortly afterwards while Austin was being readied for the plane trip, he suddenly collapsed. This time he could not be revived. Tragically he was pronounced deceased just after 2.00am.

6. Austin leaves behind broken hearted parents who are desperate to know what caused his death, and whether it could have been prevented.

7. These findings are in two parts, reflecting the two main issues which were examined at the inquest.

8. The first issue is the cause of Austin's tragic death. Here the Court was assisted with evidence from Austin's treating medical team, as well as the expert evidence of:

    - Dr Lorraine du Toit-Prinsloo, senior staff specialist in forensic pathology. Dr Prinsloo performed Austin's coronial autopsy.

    - Professor Alan Isles, respiratory specialist and Director of Respiratory and Sleep Medicine at Queensland Children's Hospital.

    - Associate Professor Andreas Pflaumer, specialist in paediatric cardiology, Royal Children's Hospital Melbourne.

9. The second issue concerns Austin's need for urgent medical transfer out of Broken Hill. Although everyone involved had Austin's best interests at heart, his transfer was afflicted with systemic deficiencies and flawed decision making. Somehow the focus on getting this little boy the hospital care he needed was lost that day.

10. The extent of this delay raised the question, were the decisions about Austin's transfer managed appropriately? The Court was assisted with evidence from the many services who were involved in the planning for his transfer, together with the expert evidence of Associate Professor Anna Holdgate, senior staff specialist in Emergency Medicine.

11. This inquest was deeply painful for Austin's parents Caroline and David. They will never forget the day they lost their little boy. Nor will they forget the long hours they waited with him for transfer to a higher needs hospital. Their sorrow is compounded by the many questions they have about his death.

Austin's life

12. At the inquest Austin's mother Caroline spoke lovingly of her son, describing him as '*a joyful little boy who loved life'*.

13. Austin was born on 6 June 2013 at Broken Hill Base Hospital, the first child of his parents Caroline Phillipson and David Facer. Austin's younger brother Rome was born in 2016, and a little sister Rio was born last year.

14. Austin was an energetic little boy who loved playing soccer, riding his bike, and playing with his little brother Rome. The death of this child has devastated his family. His parents attended each day of the inquest, and their grief and pain were clear to see. They loved Austin dearly and they grieve for him.

15. Although Rome was only three years old when Austin died, Caroline told the Court that he still constantly asks her where his brother is. Austin's parents need to know how it was that he died while in hospital care. Above all, they need to know if anything could have been done to save him.

Austin's medical history

16. Austin was a generally healthy and active little boy, but from the age of two or three years he began to experience night time coughing. The family's General Practitioner commenced him on a Ventolin puffer when he was about four. Thereafter his parents noticed that sometimes after exercise he would start to cough and needed to sit down. His mother reported that using his puffer would

generally relieve the coughing. At times however he also seemed lethargic and tired.

17. Austin was referred to paediatrician Dr Margaret Kummerow in July 2018, with concerns over lethargy and lack of weight gain. According to his mother, Dr Kummerow advised that Austin needed improved sleep and diet.

18. On 11 February 2019 Austin commenced kindergarten at Burke Ward Public School. His teacher Lauren Medcalf was made aware that he would need his Ventolin puffer if he experienced bad coughing or chest pains. The school documented five occasions between June and September 2019 when it was assumed Austin had an asthma attack. On each occasion he had been running around, before falling to the ground and reporting pain in his chest. In none of the episodes was it reported that he was wheezing.

The morning of 21 October 2019: at school

19. On 21 October 2019 Austin's mother drove him to school as usual. He was energetic and appeared to be completely well. However, at about 11.40am Austin's teacher Ms Medcalf saw him sitting down in the playground, holding his chest. He was screaming and crying, repeating the words: '*My chest hurts'*.

20. Austin was unable to walk on his own, so Ms Medcalf supported him to the school office and sat with him, while the school's First Aid officer Emily McBeth attempted to administer his puffer. However, Austin began to lose all colour to his face. His body became floppy, his eyes rolled back and he lost consciousness. He was placed on the ground in the recovery position and an ambulance was called. Austin was described as making gasping noises.

21. In the seven minutes it took for an ambulance to arrive, school staff performed emergency cardiopulmonary resuscitation [CPR]. At first they could detect no pulse or movement of Austin's chest. Ms McBeth and Ms Medcalf delivered a defibrillator shock using an automated external defibrillator [AED] device, then performed further CPR. To their relief, Austin commenced shallow but regular breathing.

22. When the ambulance crew arrived at 11.59am they found Austin unresponsive but breathing. Paramedic Simon Evitts described hearing a *'slight gurgling sound, which may have just been sputum or similar'*. The paramedics delivered oxygen and rang ahead to Broken Hill Base Hospital [BHBH], telling staff to expect a child who had collapsed and been resuscitated at school.

23. At 12.05pm, while he was still being stabilised by the ambulance paramedics, Austin again went into cardiac arrest. He stopped breathing and had no pulse. The ambulance's electrocardiogram [ECG] recorded that his heart was in ventricular fibrillation [VF]. This describes a rapid life-threatening rhythm which incapacitates the heart's pumping function, frequently leading to sudden cardiac death.

24. In response the ambulance officers resumed CPR and administered adrenaline, after which Austin slowly recovered consciousness. Then for a third time he stopped breathing and had no palpable pulse. Following CPR and adrenaline, he regained a cardiac rhythm and was able to be placed inside the ambulance.

At Broken Hill Base Hospital

25. Austin arrived in the Emergency Department at 12.34pm, and was admitted into the care of Dr Timothy Bailey, the Senior Medical Officer on shift. When Austin's distraught mother arrived at about the same time, she could hear him screaming for her. She was told this was a good sign. Austin's father David arrived at about this time as well.

26. Dr Kummerow had been summoned to the hospital and was waiting to assess Austin.

27. After examining Austin, Dr Bailey and Dr Kummerow were agreed that an asthma attack was unlikely to explain his presentation. They could find no signs of respiratory distress or wheeze. Austin's blood test results were highly abnormal, indicative, in Dr Bailey's opinion, of '*a period of impaired circulation and respiration'.*

28. Having confirmed that Austin had had an episode of ventricular fibrillation, the two doctors also agreed that he needed prompt transfer to a tertiary hospital. They decided that Dr Kummerow would attend to Austin while Dr Bailey made contact with NSW's paediatric transfer service, the Newborn and Paediatric Emergency Transport Service, known as NETS.

29. In the meantime, Austin was placed on intravenous fluids and supplementary oxygen. His blood pressure, cardiac rhythm and rate, respiratory rate and oxygen saturations were continuously monitored. He began to recover and at 2.30pm his vital signs were all measured as 'normal'. An ECG showed no significant abnormality and there was no recurrence of ventricular fibrillation. By 5.00pm he was talking and laughing with his father at his side.

30. Nevertheless, there was no doubt in anyone's mind that Austin needed transfer to a higher needs hospital, where investigations could commence into the underlying reason for his arrests. Importantly too, Austin needed to be in a hospital with life support facilities given the risk that he might suffer further episodes of ventricular fibrillation.

31. Throughout the afternoon there were numerous discussions about Austin's transfer. But it was many hours before there was a settled plan to transfer him anywhere. Initially it was agreed that he would be flown to the Women's and Children's Hospital in Adelaide, geographically the closest centre to Broken Hill. This plan did not proceed, for reasons which will be examined. Finally, almost six hours after Austin arrived at BHBH, it was resolved that he would be taken to the Children's Hospital at Westmead, Sydney. A medical team departed Sydney at 8.00pm to collect him, landing at Broken Hill at about 11.00pm.

Austin's sudden deterioration

32. At 11.08pm the retrieval team arrived at BHBH. It consisted of Dr Steven Hurwitz, a retrieval registrar and advanced trainee in paediatrics at NETS, and Registered Nurse Peter Hallman who had over 14 years' experience as a Clinical Nurse Consultant.

33. Austin seemed well when Dr Hurwitz examined him. His vital signs were within normal range and he was excited about going to Sydney in a plane. RN Hallman checked Austin's cannulae and commenced intravenous fluids. In case Austin suffered another cardiac event during the two and a half hour flight back to Sydney, RN Hallman also attached a saline bolus, an adrenaline bolus and an adrenaline infusion.

34. At 11.56pm Austin was transferred onto a stretcher and all seemed ready for his transfer to the retrieval aircraft. His father David was at his side as it had been arranged that he would travel to Sydney with Austin. Caroline was to follow the next day with Rome.

35. Suddenly Austin became distressed, with abdominal and chest pain. David described hearing him scream that he couldn't breathe. Dr Hurwitz feared this was another episode of ventricular fibrillation, but Austin's heart rhythm showed a fast rate. His oxygen saturations dropped rapidly and continued to fall.

36. Austin was intubated with the assistance of an anaesthetist. His heart rate began to drop to bradycardia, his oxygen saturations fell to below 50%, and he had no pulse. CPR commenced and a weak pulse was recovered, but this soon ceased and never returned despite further CPR and adrenaline.

37. At 2.03am all attempts at resuscitation ceased, and Austin was pronounced deceased.

What caused Austin's death?

38. Ascertaining the cause of Austin's tragic death was one of the two primary focuses of the inquest.

39. To assist the Court in determining the cause of Austin's death, the Court received reports and heard evidence from the experts referred to in paragraph 8 above.

The autopsy and discovery of Austin's coronary anomaly

40. An autopsy was performed by forensic pathologist Dr Loraine Du Toit-Prinsloo on 29 October 2019, seven days after Austin's death.

41. Dr Du Toit-Prinsloo concluded that Austin had most likely died as a result of a rare congenital condition known as '*anomalous aortic origin of coronary artery'*, which I will refer to as a 'coronary anomaly'.

42. In a heart with a normal anatomy, the right coronary artery arises from the right coronary cusp of the aortic valve, and the left coronary artery from the left coronary cusp. However when Dr du Toit-Prinsloo examined Austin's cardiovascular system, she observed that both his right and left coronary arteries arose from the right coronary cusp of his aortic valve. Dr du Toit-Prinsloo commented that this condition can be the cause of sudden cardiac death in healthy children and in young athletes, usually during or after exercise. She noted that sudden cardiac deaths are typically associated with exercise and ventricular fibrillation. She concluded that Austin's death had most likely been caused by his coronary anomaly.

43. Dr du Toit-Prinsloo noted further that according to post mortem radiology, both Austin's lungs were completely collapsed. Study of his lung tissue under microscope showed acute bronchopneumonia. Dr du Toit-Prinsloo thought this had likely developed as a result of aspiration during the initial resuscitation efforts at school, and that it had not caused his death.

44. Subsequently, Dr du Toit-Prinsloo had the benefit of reading Associate Professor Andreas Pflaumer's expert report, and in particular his opinion on whether Austin's coronary anomaly had caused his death. As will be seen, this caused her to revise her own opinion as to cause of death.

Did pulmonary infection or asthma cause Austin's death?

45. I will here mention two potential causes of death which, in the opinion of the expert witnesses, were *not* supported by the evidence. These were a pre-existing pulmonary infection, and an asthma attack I do not understand there to be any controversy as to the following evidence and conclusions.

46. A hospital chest x-ray performed at 12.34pm showed that Austin's lungs were congested. In addition, at the autopsy Dr du Toit-Prinsloo noted bronchopneumonia in his lungs. This raised the possibility that a pulmonary infection had triggered his collapse at school.

47. Respiratory specialist Professor Isles dismissed this possibility, pointing to the fact that Austin had appeared perfectly well just prior to his collapse, and that during his time in hospital his oxygen saturations improved and he remained afebrile. Professor Isles agreed with Dr du Toit-Prinsloo's conclusion, referred to in paragraph 43 above, that the bronchopneumonia observed at autopsy was likely due to an aspiration event, which is a common complication of cardiopulmonary arrest and resuscitation. I accept the opinion of these two specialists that bronchopneumonia neither preceded Austin's midday arrests, nor caused his final collapse.

48. When Austin suffered his midday arrests it was not unreasonably assumed that he was undergoing an acute asthma attack. But Professor Isles was confident that Austin's tragic death was *not* associated with asthma. Having reviewed Austin's medical records he opined that his asthma was at worst mild and very intermittent. Had it caused his collapse that day Professor Isles would have expected Austin to have been coughing, wheezing and short of breath when Ms Medcalf found him. Instead it was documented that he had chest pain, his breathing was normal, and he was able to vocalise. For similar reasons, Professor Isles queried whether Austin's episodes at school earlier in 2019 had in fact been asthma attacks.

49. Furthermore, in Professor Isles' opinion the rapidity with which Austin deteriorated to unresponsiveness that morning was not characteristic of a severe asthma attack.

50. I accept the expert evidence that Austin's death was not caused either by an antecedent pulmonary infection, or by a severe asthma attack.

51. I will mention here that Austin's father David has a recollection that his sudden deterioration at 11.30pm occurred very shortly after RN Hallman had flushed

out Austin's line with saline, to confirm the patency of the cannulas. David Facer was concerned that a medication error may have triggered Austin's collapse, perhaps a mistaken use of adrenaline rather than saline. However when questioned about this, Dr Hurwitz considered it very unlikely. He said that an accidental administration of adrenaline was not consistent with the sudden drop in Austin's oxygen saturations and his development of bradycardia.

52. I am satisfied that a medication error did not cause or contribute to Austin's sudden collapse that night.

Did Austin's coronary anomaly cause his death?

53. Reaching a conclusion as to the role which Austin's anomalous coronary artery played in his death is less straightforward. As noted by Dr du Toit-Prinsloo in her report and confirmed by Associate Professor Pflaumer in his evidence, an anomalous coronary artery can cause sudden cardiac death in healthy children during or immediately after exercise. Dr du Toit-Prinsloo had concluded that this condition had most likely been the cause of Austin's death.

54. But in his reports and evidence Associate Professor Pflaumer did not agree that the cause of Austin's death was '*very likely'* to have been his coronary anomaly. One of his reasons was the anatomical form of Austin's coronary anomaly. Coronary anomalies take different forms, which carry with them different levels of risk of sudden death. The observations of Dr du Toit-Prinsloo at autopsy had established that Austin's left coronary artery was not compressed between his pulmonary artery and his aorta, meaning there was less risk of compromise to the flow of blood to his heart. Associate Professor Pflaumer considered that this form of anomalous origin was a lower risk form of the defect, and less likely to cause sudden death.

55. Other factors persuaded Associate Professor Pflaumer that Austin's coronary anomaly was not directly implicated in his death. When Austin suffered his final collapse at 11.30pm he had not been exercising and he had not experienced ventricular fibrillation since about midday, two features strongly associated with deaths caused by this defect. Furthermore, Associate Professor Pflaumer considered it unusual that the onsite hospital clinicians had been unable to resuscitate Austin that night, which he thought was not typical of an adverse event caused by a coronary artery abnormality.

56. Associate Professor Pflaumer also considered that the features of Austin's sudden deterioration that night were not typical for a death brought about by coronary anomaly. He was here referring to the manner in which, just prior to his arrest that night, Austin's oxygen saturations dropped severely and did not

recover despite intubation. This, he said, was not typical of coronary problems caused by coronary anomaly.

57. Overall therefore Associate Professor Pflaumer thought it unlikely that Austin's coronary anomaly had caused his final collapse.

58. Professor Isles did not specifically attribute the cause of Austin's death to his coronary anomaly, and indeed had he expressed this opinion it might be considered to have been outside his area of expertise. He agreed with Associate Professor Pflaumer that there was significant ambiguity in Austin's presentation when he collapsed that night, in particular the sudden decline in his oxygen saturations.

59. At the inquest, Dr du Toit-Prinsloo expressed the view that she needed to revise her opinion as to the cause of Austin's death. She had read Associate Professor Pflaumer's opinion that Austin's coronary anomaly was unlikely to have been the cause. She accepted his opinion, and stated that in the circumstances she must find the cause to be '*unascertained'.*

60. The above evidence compels the conclusion that Austin's coronary anomaly was not the direct cause of his fatal collapse that night.

Can a cause for Austin's death be found?

61. Counsel Assisting has proposed in closing submissions that the evidence may not enable the Court to find a definitive cause of death for Austin.

62. For reasons which will be explained, I accept that this is the case. Whether there is sufficient evidence to satisfy a finding on the balance of probabilities will therefore be considered

63. In submissions on behalf of Austin's family it was urged that while a definitive cause of death may not be available, the Court could reasonably find on the balance of probabilities that Austin's death was *'cardiac in origin, in that it was caused by complications associated with his anomalous coronary artery condition'.* It was submitted that since this finding was supported by the evidence, it ought to be made, in the interests of providing Austin's parents with the comfort of some degree of closure.

64. This submission rests upon acceptance of two subsidiary propositions:

- that Austin's earlier arrests were most likely due to his coronary anomaly; and

- that his fatal collapse was related to his earlier arrests that day.

65. As to the second proposition, the family relied upon the evidence of Associate Professor Pflaumer and Professor Isles that Austin's midday arrests and final collapse were very likely related, meaning that his final collapse should be seen as forming part of a larger sequence of medical events.

66. In submissions in reply, Counsel Assisting agreed that it was open to the Court to find that the background to Austin's death included the earlier arrests that day.

67. I accept this submission. In his oral evidence, with which Professor Isles agreed, Associate Professor Pflaumer said it was '*very very unlikely'* that the earlier and the later events were unrelated. The evidence at inquest meets the test for a finding that Austin's death took place on a background of the earlier arrests that had taken place that day.

68. As to the cause of the earlier arrests, in his oral evidence Associate Professor Pflaumer speculated that these might have been associated with his coronary anomaly. He noted features of the earlier arrests which were consistent with deaths due to coronary anomaly, namely exercise and the presence of ventricular fibrillation.

69. Nevertheless, neither in his report nor in his evidence did Associate Professor Pflaumer consider this association to be any higher than that of a possibility. He remained dubious as to the role of the coronary anomaly in any of Austin's arrests, due to it being a variant '*not very likely to cause death'.*

70. In light of Associate Professor Pflaumer's consistent opinion on this point, I am not able to accept the family's submission that Austin's earlier arrests '*were clearly associated with the coronary anomaly'*. The evidentiary burden of a finding on the balance of probabilities cannot be met on the basis of the above evidence.

71. Furthermore, although the evidence establishes a relationship between Austin's fatal collapse and the earlier arrests, it is not sufficient to identify what the nature of that relationship was. While both Associate Professor Pflaumer and Professor Isles agreed that Austin's earlier arrests must have been connected in some way with his final collapse, they were not able to determine what that causal relationship was.

72. On this point Associate Professor Pflaumer again offered comments which would fairly be described as of a speculative nature. Referring to the clinical features of Austin's final collapse he said:

> *'Given the presentation with low saturations I wonder if secondary problems after the first resuscitation with two consecutive arrests affecting his airways might have played a role'.*

73. In his oral evidence he hypothesised that the earlier arrests and resuscitations might have brought about '*secondary problems …. affecting his airways'*, which played a role in Austin's final collapse.

74. It is evident that Associate Professor Pflaumer wished to assist the Court, and Austin's parents, in identifying a cause of death for this little boy. However, he was unable to find it any more than '*possible*' that Austin's coronary anomaly had triggered the earlier arrests. As a result, it is not open for me to find, as urged by the family, that his later and fatal collapse more likely than not arose from complications of an arrest caused by that condition.

75. However, I do not understand the expert evidence as precluding a finding that Austin's earlier arrests were clearly *cardiac* in origin. Although Professor Isles and Associate Professor Pflaumer were uncertain that the direct cause of Austin's later collapse was cardiac in origin, they were confident that the earlier arrests were. Professor Isles' firm opinion, expressed both in his reports and his evidence at inquest, was that the cause of Austin's death was cardiac in nature. As noted, he was emphatic that Austin's presentations both in his midday collapses and his fatal collapse were not consistent with that of a child suffering a severe asthma attack. In his opinion, they:

> '*…could easily have been cardiac related rather than asthma in that they were related to chest pain rather than shortness of breath or wheezing'.*

76. In his oral evidence, Associate Professor Pflaumer expressed agreement with Professor Isles that Austin's earlier arrests were likely cardiac in origin, although as noted he doubted the trigger was Austin's coronary anomaly.

77. Given the degree of certainty in the evidence that Austin's earlier arrests were cardiac in origin, and that his later collapse formed part of a larger sequence with those earlier events, I consider that the evidence supports a finding that Austin died as a result of cardiopulmonary arrest on a background of earlier cardiac arrests and resuscitations.

78. Before leaving the medical evidence, I will mention two further matters.

79. At the inquest Associate Professor Pflaumer was asked if Austin's coronary anomaly ought reasonably to have been detected during the course of his short life. Associate Professor Pflaumer did not think so. He commented that coronary anomalies are not only rare, but also very difficult to detect. Symptoms were not usually associated with it, sudden cardiac arrest being for most patients the first symptom experienced. Although it can be detected with echocardiography under general anaesthesia, this is usually only in circumstances where the examiner suspects its presence. Associate Professor Pflaumer said that other methods of diagnostic testing are difficult to perform with young children.

80. Secondly, the expert medical witnesses were asked to comment on the adequacy of the medical treatment which Austin received at BHBH that day, including the response to his emergency at 11.30pm. Both Professor Isles and Associate Professor Holdgate considered Austin's clinical treatment to have been *'entirely appropriate in the circumstances*'. Furthermore, Professor Isles commended the school's medical response to Austin's collapse as '*exemplary'*.

The planning for Austin's transfer

81. The second focus of the inquest was the extensive delay which accompanied decisions about Austin's transfer out of Broken Hill.

82. In brief, the paediatric transfer service NETS first became involved in Austin's case at 12.41pm that day. But more than five hours passed before there was a settled plan that Austin would be transferred to Sydney. This was an agonising wait for Austin's parents, who had been told that he needed transfer to a higher level hospital. Worse still, the evidence at inquest established that for the most part these delays were avoidable.

Paediatric retrieval processes

83. Like most hospitals in remote and rural areas, BHBH does not have a paediatric intensive care service. Critically ill infants and children rely upon the NETS service for advice or for transfer to a higher level hospital. Medical specialists working with NETS provide both an advisory service for clinicians with paediatric patients, and an emergency retrieval service. These services are managed via a hotline in Sydney.

84. It is not suggested that the urgent transfer of patients from remote areas is a straightforward process. The following brief description illustrates the challenges involved.

85. Transfer of a patient from a remote area requires coordination between the separate medical teams caring for the patient prior to the flight, during the flight, and at the receiving hospital, as well as the agencies which provide the aircraft and pilot. There are further complications when, as in Austin's case, transfer is being considered to another state.

86. NETS consultants use conference calls to provide advice and to arrange paediatric retrievals to higher level hospitals. In the case of retrievals, conference calls typically involve the NETS consultant, the clinicians at the local hospital, and relevant specialists at the receiving hospital. The NETS consultant must also source a clinical transfer team, and an aircraft and crew.

87. For critically ill or urgent child cases in Broken Hill, there is a longstanding informal arrangement that they will be referred to the Women and Children's Hospital in Adelaide [WCHA]. This is because it is the closest higher level hospital to Broken Hill.

88. When arranging a paediatric transfer from Broken Hill to Adelaide, NETS consultants need to liaise with consultants within the equivalent South Australian retrieval service, MedSTAR. MedSTAR consultants route the NETS consultant through to relevant clinical experts in Adelaide for their advice and patient acceptance. The Court heard that in most cases where WCHA accepts a Broken Hill patient, MedSTAR provides the medical and transport team.

89. The State Director for NETS is Dr Andrew Berry. In his statements and evidence at the inquest he identified a problem with interstate retrievals which was of particular significance. He explained that when an interstate retrieval service has been engaged for a NSW patient:

> *' …there is a sense that the care, decision-making and governance is now with the adjoining state – even if the patient is still in NSW and in a NSW hospital. Unfortunately while the patient remains in NSW, it isn't clear about who remains clinically responsible for the patient …'*

90. He emphasised the need for *'cross-border agreements about clinical and operational collaboration between the jurisdictions',* to ensure that transfer decisions were made efficiently and proceeded in a timely way.

91. As will be seen, Dr Berry's evidence about this issue was of particular relevance to Austin's case.

The first NETS conference call

92. Examination of the delays in Austin's transfer commenced with what has been called '*the first NETS conference call'*.

93. This call marked NETS' first involvement with Austin's case. As will be seen, it did not involve any active discussion about whether Austin ought to be transferred out of Broken Hill, a feature as to which Associate Professor Holdgate expressed criticism.

94. On 21 October 2019, paediatrician Dr Fiona Mitchell was the NETS on call retrieval consultant. At 12.41pm she received a call from Dr Neil Ballard about the arrival at BHBH of a six year old boy. Dr Ballard is a retrieval consultant with the Aeromedical Control Centre, the service which transfers adult patients. He had been monitoring the NSW Ambulance electronic system that morning, and had noticed the relatively rare report of a child who had suffered a cardiac arrest at school.

95. Dr Mitchell asked to be connected to the Emergency Department at BHBH, and in the meantime patched Dr Hari Ravindranathan into the call. Dr Ravindranathan is a paediatric intensivist at Sydney Children's Hospital, Randwick. Dr Mitchell wanted the BHBH doctors to have the benefit of his recommendations for Austin's immediate care.

96. Dr Mitchell had just commenced speaking with Dr Ravindranathan when Dr Kummerow joined the call. At this stage Austin had been in the Emergency Department for less than fifteen minutes. His clinical picture was unclear, and she had not yet had the opportunity to fully assess him.

97. Dr Kummerow advised Dr Mitchell and Dr Ravindranathan that Austin had a history of asthma, that he had reportedly gone into ventricular fibrillation, and that he was receiving airway support. She concluded with the words:

> *'So, I mean the way he's responding he … he should be fine to stay here and I don't think we'll need your* [NETS'] *help'.*

98. Dr Ravindranathan asked Dr Kummerow to perform an ECG to ensure Austin did not have any conduction abnormalities, which Dr Kummerow agreed to do. The phone conference then concluded, with Dr Mitchell inviting Dr Kummerow to call NETS '*if you need advice … call back if you need it'*.

99. It was to be another forty minutes before NETS became involved again. At 1.30pm Dr Bailey rang Dr Mitchell, to report that he and Dr Kummerow were

now clear that Austin had undergone ventricular fibrillation during his collapse at school, and that he required transfer to a hospital with high level paediatric care. It was only then that Dr Mitchell commenced making arrangements for Austin's transfer.

100. In her report and evidence, Associate Professor Holdgate queried why Austin's transfer was not an active part of the discussions in this first call. Regarding Dr Kummerow's comment that Austin '*should be fine'* to stay at Broken Hill, A/P Holdgate said:

> *'Although Austin's condition at this point was relatively stable, he had experienced a VF arrest which is an extremely rare event in children….*
>
> *…Despite Dr Kummerow's confidence that she could adequately manage Austin at BHBH, the crucial care doctors at NETS should have identified the inappropriateness of this decision and arranged for urgent transfer of Austin to an appropriate facility'*.

101. Associate Professor Holdgate conceded that Dr Kummerow had been in a difficult situation, having had only a few minutes to receive information about Austin. Nevertheless, she maintained that there ought to have been greater proactivity in confirming the reported ventricular fibrillation. This would have put beyond question the need for an urgent transfer.

102. In response, Dr Kummerow said that her comment that Austin '*should be fine to stay here'* was not intended to express a concluded view about whether transfer was necessary. Rather, she intended to perform a proper assessment and then call NETS back.

103. But while this may have been Dr Kummerow's intention, it was not reflected in what she said in the call. Nor does the transcript of the call support the assertion she made in her statement, that she told Dr Mitchell she would contact her '*as soon as the assessment was made'.*

104. It is also clear that Dr Mitchell was not left with any expectation that Dr Kummerow would call her back once she had assessed Austin. This is reflected in her comment to the group in the second NETS conference call, that '*she* [Dr Kummerow] *said she'd call back if she wanted more advice'.*

105. Taking the above into account, I accept the submission of Counsel Assisting that Dr Kummerow's comment had the effect, for the time being at least, of putting to an end any exploration of transfer for Austin.

106. In fairness to Dr Kummerow, I accept that her comment ought to be regarded more as a failure of communication than an error of clinical judgement. It is evident that shortly after this call she was in full agreement with Dr Bailey that Austin needed to be transferred out of Broken Hill.

107. The inquest also considered whether the approach taken by Dr Mitchell in this call was appropriate in the circumstances.

108. It can be seen that Dr Mitchell did not actively pursue the question of whether Austin required transfer. At the inquest, she recalled having felt '*a little anxious'* at hearing from Dr Kummerow that Austin could remain at Broken Hill. However, she said that she did not see her role as directing Dr Kummerow or BHBH staff what to do with Austin. Accordingly, she took no further action until Dr Bailey called her forty minutes later.

109. Associate Professor Holdgate considered that the manner in which Dr Mitchell managed the first NETS conference call was:

> *' … a missed opportunity to actively seek more information and provide advice that a child who has had an arrest which turned out to be a VF arrest and in fact had two VF arrests is not appropriate to stay at Broken Hill.'*

110. Counsel Assisting has submitted that:

> *'The Court could reasonably find that the information about a possible VF arrest should have elicited a more assertive response from the NETS consultant …'*

111. The suggested deficiencies in Dr Mitchell's approach were identified as:

> ' … *not sufficiently identifying the potential issue (VF), not enquiring further into the need to address it, and not urging call back and flagging the need to organise consequential retrieval if indeed VF had occurred'.*

112. On behalf of Dr Mitchell, it was submitted that this criticism did not take account of the different approach which NETS takes to transfer decisions, when compared with that taken by adult retrieval services. Secondly, it was submitted that at the time of the first NETS conference call, there was not sufficient information to discuss transfer as there remained the need to confirm Austin's reported ventricular fibrillation.

113. Regarding the first submission, the Court heard evidence that NETS consultants provide a broader service than do their counterparts in adult retrieval. At the inquest Dr Mitchell, Dr Berry and Medical Director at Sydney Children's Network, Dr Mary McCaskill, explained that NETS offers an advisory

service to clinicians across NSW, who are encouraged to call NETS early for specialist advice about the care of their infant and child patients. They explained that many such cases did not involve the need to consider transfer at all.

114. The Court heard that this broader and more consultative approach extends to cases where transfer of a child patient is under consideration. In such cases the NETS consultant typically takes a less assertive approach, aiming for collaboration with clinicians and specialists at both the referring and receiving hospitals. The NETS witnesses attested to the benefits delivered to children and their families by this more collaborative model.

115. It can be accepted that there are well founded differences in the approach to transfer taken by paediatric and adult retrieval services. However, given the unanimity of clinical opinion that ventricular fibrillation represents a serious medical situation, it is not clear why the consultative model preferred within NETS precluded Dr Mitchell from encouraging urgent confirmation of its presence. Had she done so, there would have been a speedier transition to planning for transfer. It is surely not the case that a collaborative approach precludes efficient decision making.

116. Regarding the second submission, that in the first call there was not sufficient information to commence a discussion about transfer, it is the case that Dr Kummerow had not yet confirmed to Dr Mitchell that Austin's arrests had involved ventricular fibrillation.

117. This being so it is difficult to understand why, instead of leaving matters to the BHBH clinicians, Dr Mitchell did not make it a priority to confirm Austin's reported ventricular fibrillation.

118. I accept the submission of Counsel Assisting that a more proactive response from Dr Mitchell in the first NETS conference call would have been beneficial. This would presumably have involved her seeking prompt confirmation of the ventricular fibrillation event, then moving swiftly into planning for a transfer. It is, with respect, misconceived to submit that a finding to this effect fails to take account of the consultative NETS approach to transfer decisions.

119. It is to her credit that at the inquest, Dr Mitchell stated on more than one occasion that in hindsight, she wished that during the first conference call she had asked the BHBH doctors to obtain the ECG trace and immediately contact her once they had done so.

120. Was the intervening period of forty minutes between the first and second NETS conference calls significant? It was submitted on behalf of Dr Kummerow and

Dr Mitchell that even if transfer had been actively discussed in the first call, it could not be demonstrated that this would have averted the tragic outcome for Austin.

121. I will return to this question later in the findings. At this stage, it suffices to say that although this period represented a small proportion of the overall delays that afternoon, it would be entirely understandable if Austin's parents did not see the matter in this light. They had been told that Austin needed higher level care at a tertiary hospital. As the hours stretched on and Austin remained in Broken Hill, their anxiety and distress must have been very great.

122. I will now return to the narrative of the afternoon's events.

The second NETS conference call

123. This call commenced at 1.32pm and concluded at 2.14pm. The chief participants were Dr Mitchell, Dr Bailey, and Ms Nichole Kerr, Nurse Consultant at MedSTAR. Unfortunately, MedSTAR's on call retrieval consultant, Dr Paul Lambert, was not a party to the call as he was temporarily unavailable.

124. As mentioned, Dr Bailey confirmed that Austin's earlier collapse had involved an episode of ventricular fibrillation. He and Dr Mitchell quickly reached agreement that Austin needed transfer to a tertiary hospital. Then followed discussion as to whether WCHA would be a suitable destination. They concurred that transfer to WCHA would be in accordance with the usual referral pathway for Broken Hill paediatric patients.

125. During the call Dr Mitchell sought the advice of a paediatric cardiologist at WCHA, Dr Karina Laohachai, as to whether her hospital had the capabilities to treat Austin.

126. Dr Laohachai came on the line and heard the details of Austin's collapse and his current condition. She advised that if anything like a pacemaker or defibrillator had to be inserted, Austin would have to be transferred on to Melbourne. Overall however, she was satisfied that WCHA was appropriate:

> *' ..I think that, you know, in him being six years of age, the chance of him needing something is probably more unlikely than likely …but I'm just saying that if we do need something like a defibrillator we wouldn't do it here.'*

And later in the call:

> *' ..I would be happy to accept him to assess and see what it is … with other previous cases we would probably just accept them and then assess and then if*

we just need to transfer we would, because I think it's more likely we should be able to stabilise him medically first before we need to do anything further'.

127. Dr Ballard, who was also on the line, told the group that a transfer team would be available very shortly to take Austin to Sydney. He therefore encouraged a resolution of the destination '*sooner rather than later'*.

128. Concerned that if Austin was transferred to Adelaide he might need a further transfer to Melbourne, Dr Mitchell sought the advice of another consultant, Dr Jonathan Egan. Dr Egan is an intensivist consultant at the Children's Hospital at Westmead in Sydney.

129. Dr Egan was ultimately of the same view as Dr Laohachai, that overall WCHA would be an appropriate destination for Austin. Dr Bailey added his approval of this plan, stating that they were all *'splitting hairs and …we're playing what-ifs …'.*

130. Dr Laohachai then asked if Austin would be admitted to WCHA's Paediatric Intensive Care Unit [PICU]. It was agreed that MedSTAR's retrieval consultant Dr Paul Lambert would be asked to canvass this with the PICU consultant, Dr Andrew Clift.

131. MedSTAR's Ms Kerr then told Dr Bailey she would call him back once MedSTAR had arranged a retrieval team and an estimated time of arrival.

132. Dr Mitchell considered at this point that responsibility for Austin's transfer was now with MedSTAR. She invited Dr Bailey to contact NETS if he had any ongoing issues with Austin's care. This ended the second NETS conference call.

133. It can be seen that all participants to this call accepted that WCHA was an appropriate destination for Austin, notwithstanding the possibility, described by Dr Laohachai as *'small'*, that he might need further care in another hospital. It was also understood that MedSTAR would be responsible for Austin's transfer there.

134. But Austin was never transferred to Adelaide. Following MedSTAR's foreshadowed conversation with Dr Clift, the plan was derailed by a lengthy and ultimately fruitless detour exploring a transfer to Melbourne instead. Three hours after the end of the second NETS conference call, there was no settled plan to transfer Austin anywhere.

135. The events of this period, from 2.14m to 5.32pm, will now be examined.

MedSTAR's discussions with WCHA

136. At 2.33pm, MedSTAR retrieval consultant Dr Lambert spoke with WCHA intensivist Dr Andrew Clift about the planned transfer of Austin to his hospital.

137. It transpired that Dr Clift was not comfortable with the plan to bring Austin to WCHA. He was concerned that if Austin suffered another cardiac arrest, he might need extracorporeal membrane oxygenation [ECMO], and WCHA did not have this facility. ECMO is an advanced form of life support, which circulates the patient's blood outside their body and through a machine to exchange carbon dioxide and deliver oxygen.

138. Dr Lambert responded:

> *'We should probably discuss that with cardiology before we start moving people around'*.

139. This was a perhaps surprising response, given that in the second NETS conference call WCHA's paediatric cardiologist Dr Laohachai had endorsed Austin's transfer to her hospital, notwithstanding that it did not have certain advanced facilities.

140. Dr Clift agreed to raise this issue again with Dr Laohachai. Not surprisingly he wanted to see Austin's chest x-ray and ECGs, so Dr Bailey was obliged to send these to yet another clinician involved in the consultations.

141. Almost an hour after this conversation, Dr Laohachai reported back to Dr Lambert on her discussions with Dr Clift. She reiterated her opinion that admitting Austin to WCHA was a matter of accepting the risk that he might need ECMO, which she described as:

> *'...small but as Andrew* [Clift] *says, it's not zero'.*

She went on to say:

> *'I'm not going to push for him to definitely come here but ... I guess... the fact, the risk ... the chance of him needing additional support such as ECMO is ... low'*.

142. She mentioned also that Adelaide was a better destination for Austin's family.

143. Dr Lambert decided to '*go back and revisit the feasibility of transferring him to different places'.* He said that he would '*see if I can find a way of getting him into Melbourne'*.

144. It was now 3.34pm, eighty minutes after the end of the second NETS conference call. The separate discussions between Dr Lambert, Dr Clift and Dr Laohachai had occupied most of that time.

145. This sequence of calls invited the question whether, if Dr Clift's response to the Adelaide plan was considered necessary, his input could not have been obtained in a more efficient manner. Why for example, could he not have been patched into the second NETS conference call, where his concerns could have been communicated immediately and to the group as a whole? I will return to this question.

146. In the meantime, Austin's parents were becoming understandably stressed. Two hours earlier Dr Bailey had told them that their son had to be transferred out of Broken Hill to receive the care that he needed. Dr Bailey said that when Caroline and David received this news:

> '*they (together with those of us involved in* [Austin's] *care) seemed very relieved.'*

147. But as time went by David and Caroline became increasingly distressed. Dr Bailey said that by 3.00pm David Facer was '*very upset'.* Caroline said that '…a*bout 3pm there was still no sign of* [Austin] *being flown out'*, and that she kept asking '*what is taking so long?'*

Enquiries about a Melbourne transfer

148. After his conversation with Dr Clift, at 3.49pm Dr Lambert had a critical conversation with Dr Bailey. Dr Lambert told him:

> '… *we've got the option of transferring* [Austin] *to a place with ECMO versus a place without ECMO … if it could happen reasonably easily then it's probably the way to go'*.

149. In response Dr Bailey mentioned the second NETS conference call, and the consensus that '*the probability is that he'll be able to be treated in Adelaide'*. However, Dr Lambert replied that he thought Melbourne would be *'our preference if it can be made to work'*.

150. Dr Bailey then brought up a significant problem: the fact that Melbourne is rarely if ever a direct referral destination for Broken Hill patients. As Dr Bailey pointed out to Dr Lambert, he had '…*no idea of what facility in Melbourne we're talking about'*.

151. Despite this, Dr Lambert suggested to Dr Bailey that he (Dr Bailey) make enquiries as to whether Austin could be transferred to Melbourne. MedSTAR's Nurse Consultant provided Dr Bailey with the phone number for Victoria's Paediatric Infant Perinatal Emergency Retrieval service [PIPER], and suggested that he ask for their paediatric retrieval consultant.

152. After this, MedSTAR and Dr Lambert had no further involvement in discussions or arrangements for Austin's transfer.

153. Dr Bailey now commenced the ultimately fruitless exploration of a Melbourne transfer. At 3.58pm he made contact with PIPER consultant Dr Ben Gelbart. Dr Gelbart echoed Dr Bailey's initial surprise at the suggestion of a transfer to Melbourne. As he described it in a later phone conference:

> '*Well for some reason, after all that decision making, Dr Bailey from Broken Hill has called me, I'm not sure on … I can't recall on whose advice, but they've then subsequently referred to Melbourne. So it seems like it's becoming a bit circular.'*

154. Nevertheless, Dr Gelbart agreed to make enquiries. He too needed to be sent Austin's chest x-ray and ECG, and to review these. Almost an hour later, his attempts to identify a suitable Melbourne hospital had elicited the information that no cardiac electrophysiological facilities would be available in Melbourne that week. There was therefore little point in taking Austin there.

155. An hour and a half had thus been wasted pursuing the option of a Melbourne transfer. The discovery that Melbourne had no electrophysiological facilities that week caused the focus to shift once more to a transfer to Sydney.

156. NETS, left out of the picture since 2.14pm, now became involved again.

The reinvolvement of NETS

157. Just before 5.00pm, NETS retrieval consultant Dr Swapnil Shah took a phone call from Dr Gelbart about a possible transfer of Austin to Sydney.

158. Dr Shah had received a handover from Dr Mitchell at around 3.30pm that Austin was to be taken to Adelaide by MedSTAR. He was surprised to learn from Dr Gelbart that Austin was still at Broken Hill, and that there was still no arrangement to transfer him anywhere.

159. Dr Shah agreed to speak with cardiologist and intensivist specialists at Westmead Children's Hospital.

160. By 5.44pm it was settled that Austin would be accepted there for further cardiology evaluation. A NETS medical team flying from Sydney would transport him. The medical team would be available from 7.00pm, and the flight crew from 8.00pm. They were expected to arrive at Broken Hill at approximately 11.00pm.

161. I have described above the arrival at BHBH of the NETS retrieval team later that night, and the tragic events that followed.

Was it appropriate to depart from the Adelaide plan?

162. By 2.14pm on 21 October 2019 there had been recognition that Austin needed urgent transfer to a tertiary hospital, and broad agreement that he would be taken to WCHA. The departure from this plan resulted in there being no settled transfer plan for Austin until almost 6.00pm that evening.

163. Was it clinically justified to depart from the Adelaide plan at all, given the small chance that ECMO would be required? Counsel Assisting submitted that it was not, and that the shift in focus to the small possibility of Austin needing ECMO clouded the primary need for his speedy transfer to a tertiary hospital.

164. I have concluded that this is correct. There is no question that all involved had Austin's best interests at heart. But the conclusion is inescapable that systemic deficiencies and flawed decisions created long and avoidable delays that

afternoon. Most of these flowed from MedSTAR's decision to depart from the original Adelaide plan.

165. It is clear that the clinicians involved in the second NETS conference call were aware that WCHA did not have some facilities for advanced care which were available in Sydney and Melbourne. The consensus they reached was that whether Austin would ultimately require these facilities was speculative, and was outweighed by the need to get him to a tertiary hospital for assessment. It was not submitted on behalf of any interested party that this was not a sound assessment.

166. In her report A/P Holdgate endorsed this conclusion, opining that for Austin a prolonged period in BHBH carried ongoing risk due to:

> ' … *the uncertainty regarding his underlying diagnosis and the recognised risk of further malignant arrhythmias'.*

He required '*prompt transfer'.*

167. The assessment that Adelaide was a reasonable destination was also supported by Dr Berry, Associate Professor Pflaumer and Professor Isles. The latter two witnesses acknowledged they were not experts in the use of ECMO. Nevertheless Associate Professor Pflaumer is a paediatric cardiologist and the Court would place some weight on the opinion he expressed, based on his experience, that placing children on ECMO carries significant risks. In addition, Associate Professor Pflaumer queried whether use of ECMO would have been considered an effective option, even in the event that Austin had been transferred to Melbourne or Sydney and had collapsed there. This was due to the possibility that Austin would have suffered severe post-collapse hypoxic damage before he could be prepared to receive this intervention.

168. These considerations caused Associate Professor Pflaumer to conclude that the availability of ECMO and other advanced facilities '*should not delay the primary transport to a centre with the ability to start further diagnostic steps and which can provide care on a tertiary level'.*

169. Given the weight of the evidence, I accept the submission that even without the benefit of hindsight Adelaide was an appropriate and reasonable destination for Austin. The pressing need for him to be taken to the nearest tertiary hospital outweighed the speculative nature of any concern that he might need facilities not available for him at Adelaide.

170. It remains unclear whether it was necessary to have Dr Clift's acquiescence in Austin's proposed transfer to WCHA, given that Austin required specialist cardiac management and Dr Laohachai had endorsed his admission there. This was not an issue which was explored at the inquest.

171. Perhaps it may be accepted that since Dr Clift was the intensivist at the proposed receiving hospital, it was at the least desirable that he be consulted.

I have outlined above the inefficiency and cost in time which attended this process of consultation.

172. In their evidence Dr Laohachai and Dr Berry spoke of the importance, in cases of urgent paediatric retrieval, of the simultaneous involvement of retrieval consultants, clinicians from the local hospital, and clinicians from the receiving hospital. This was acknowledged in submissions on behalf of MedSTAR.

173. Without doubt, in Austin's case the decision making about the appropriate destination would have been hastened by bringing Dr Clift into the second NETS conference call. It remains unclear whether the failure to do so was the result of systemic deficiency or individual oversight.

174. The need for clarity about these matters is addressed later in these findings.

Was it appropriate to explore a transfer to Melbourne?

175. The protracted process of obtaining Dr Clift's input was then compounded by Dr Lambert's decision to explore Melbourne as an alternative destination. This exercise was abandoned at approximately 5.00pm, when it was realised that Melbourne hospitals had no electrophysiological services that week.

176. In his phone conversation with Dr Lambert at 3.49pm, Dr Bailey had adverted to the difficulty that Broken Hill patients are not commonly transferred directly to Melbourne. The Court heard evidence that in the previous two years, of 930 patient transfers out of Broken Hill, 802 went to South Australia. Of these, 19 of 21 were paediatric cases within the life threatening category.

177. At the inquest Dr Lambert candidly acknowledged that he did not know at the time if PIPER provided direct transfer from Broken Hill. As submitted by Counsel Assisting, he really '*had no reliable way of knowing whether* [a Melbourne transfer] *was viable within a suitable timeframe'*.

178. When questioned about this at the inquest, Dr Lambert said that he had expected Dr Bailey would call him back quickly to say that Melbourne had declined the transfer, and they would then look at other options.

179. The flaws in this thinking are evident. As the transcript of their phone conversations show, at no point did Dr Lambert advise Dr Bailey to make only brief enquiries before getting back to him. Nor, during the period 3.49pm to 5.00pm while Dr Bailey was engaged in this task, did Dr Lambert made any enquiries as to his progress, or do anything else to assist him.

180. Furthermore, it was not reasonable for Dr Lambert to expect that Dr Bailey would achieve a speedy response to the question of a Melbourne transfer. It was evident that he had no established contacts to facilitate his mission. I note his enquiry to Dr Lambert about what Melbourne facility to contact, and who he should speak to.

181. In addition, it was entirely foreseeable that whoever Dr Bailey spoke to in Melbourne would require the kind of clinical data about Austin that all other clinicians had hitherto required. This introduced further delays.

182. Most importantly, it was not Dr Bailey's responsibility to perform this task. It was indisputable that the responsibility for seeking a substitute retrieval process lay not with Dr Bailey but with MedSTAR, the service which had taken original responsibility for Austin's transfer.

183. These deficiencies were summed up in Associate Professor Holdgate's report:

> '*Dr Bailey could not be expected to know the various specialty skill sets at the various locations or the logistics of arranging such transfers. He was a clinician working on site with ongoing responsibilities to manage Austin and see and treat other patients. Having initiated the retrieval process he was not responsible for how this was enacted. Having decided that Austin should not be transferred to Adelaide, the staff at MedSTAR should have recontacted NETS to arrange transfer to an alternative destination'.*

184. The conclusion offered by Counsel Assisting is inescapable, that MedSTAR:

> '… *lost sight of the inevitable delay in transfer that would be occasioned by trying to put in place a retrieval to Melbourne and abandoning the pre-agreed Adelaide transfer'.*

185. At the inquest Dr Lambert said that he had reflected on the decisions he made that afternoon. He acknowledged that he should not have delegated to Dr Bailey the task of exploring a Melbourne transfer. He also recognised that once he had become aware of Dr Clift's concerns, he should have proceeded to a multi party conference rather than the sequential and time costly discussions which then took place.

186. Dr Lambert acknowledged, in effect, a loss of focus on his part that afternoon which although unintentional, led to extensive delays.

Did the delays make a difference to the outcome for Austin?

187. The evidence established that significant flaws in the planning for Austin's transfer led to unacceptable delays. Would a speedier transfer have made a difference to Austin's chances of survival?

188. The evidence at inquest strongly supports the submission of Counsel Assisting, that a timely transfer to a tertiary hospital had the potential to improve Austin's chances of survival. The family concurred with this submission.

189. Associate Professor Pflaumer, Dr Laohachai and Associate Professor Holdgate all confirmed that if Austin had been admitted to WCHA he would have had access to specialists and subspecialists with experience in cardiac arrest in children. WCHA would have offered a range of diagnostic facilities to investigate the underlying cause of his cardiac arrests that morning. Associate Professor

Pflaumer and Dr Laohachai identified echocardiography as important to this diagnostic task, as well as, in the opinion of Dr Laohachai, CT angiogram.

190. Neither Associate Professor Pflaumer nor Professor Isles felt able to positively state that a speedier transfer would have prevented this tragic outcome for Austin and his family. This was because of their uncertainty as to the underlying cause of Austin's earlier cardiac arrests and subsequent fatal collapse. As Associate Professor Pflaumer pointed out in his evidence, whether Austin's death could have been prevented depended on what the medical investigations at Adelaide might have revealed.

191. I accept that it remains unknown whether a speedier transfer would have prevented Austin's death. For Caroline and David however there can be little comfort in this conclusion. A more timely transfer had the potential to improve their little son's chances of survival. They will always ask themselves if he might have lived, had this transfer not taken so long. And the long wait that afternoon and evening must have been harrowing for them.

192. There is another reason why it was important to examine the extensive delays in Austin's transfer. Patients in remote areas like Broken Hill who are in need of urgent transfer deserve to have the earliest possible access to full hospital services, like patients elsewhere in NSW. An inquest is an opportunity to identify if systemic deficiencies stand in the way of this, and if they can be improved with good will and cooperation.

What changes are needed?

193. An inquest is forward-thinking, in that it aims to reduce the risk that further tragedies like this will occur. Austin's inquest has identified a need to improve the way we arrange the transfer of children to hospitals which can meet their needs.

194. I accept the submission of Counsel Assisting, that the evidence at inquest established clear systemic deficiencies in Austin's retrieval process. There was a lack of clarity as to which service 'owned' this transfer. This together with suboptimal decision making led to failures in communication and planning.

195. Counsel Assisting identified as a significant failure, that MedSTAR did not notify NETS when uncertainty developed about the plan to transfer him to Adelaide. Had MedSTAR done so, NETS must have intervened at that stage. This would have averted the protracted discussions which followed about whether Adelaide was a suitable destination, and the ultimately futile exploration of a Melbourne transfer.

196. There is no dispute that MedSTAR ought to have notified NETS at that point. As Associate Professor Holdgate identified in her report, notwithstanding that MedSTAR was engaged to transfer Austin out of Broken Hill, he remained a patient within a NSW hospital and under the care of NSW clinicians until he actually left NSW.

197. The lines of responsibility were of course complicated by the fact that although NETS retained primary responsibility for Austin's care, the organising of his transfer fell to MedSTAR.

198. At the inquest, there was senior level agreement with Associate Professor Holdgate that such cross-border complications can only be accommodated with a clear understanding that NETS retains responsibility for a Broken Hill patient until the patient has actually left the State and furthermore, that NETS exercises this responsibility by remaining actively involved in the transfer arrangements.

199. These propositions were accepted by Dr Berry, Dr McCaskill, and Dr Andrew Pearce, the Director of MedSTAR's Clinical Services. In his second statement Dr Berry said:

> *'There is an urgent need to embed a new practice arrangement with interstate services to ensure there is one overall coordinating lead which 'owns' the problem presented and coordinates all aspects.'*

200. Dr Berry outlined a number of changes he wanted to see. These included certainty that:

a. NETS maintains direct communications and clinical oversight of a patient, until an interstate team leaves Broken Hill with the patient

b. MedSTAR communicates with NETS and not with BHBH, in the event that MedSTAR does not accept or later declines a retrieval; and

c. there are clear operational and clinical processes established between the primary services involved, being NETS, MedSTAR, and WCHA.

201. Dr Pearce indicated his support for the above proposals.

The question of recommendations

202. I accept the submission of Counsel Assisting, that the evidence at inquest established:

> ' …*a well-founded need for settled guidelines to be agreed between NETS and MedSTAR about a range of matters'*.

203. These included agreement as to NETS/MedSTAR conference calls, in particular guidance as to which clinical consultants ought to be included, and how their input is to be obtained in the most efficient and time-sensitive manner.

204. Other matters of importance included:

- agreement as to whether urgent or critically ill paediatric patients are to be accepted to Adelaide regardless of bed availability; and

- how patients' clinical information may efficiently be shared with clinicians involved in the transfer planning.

205. Both Dr Berry and Dr Pearce expressed their commitment to settling guidelines in the above areas. These matters are the subject of proposed Recommendations 1 and 2.

206. I also endorse the proposal of Counsel Assisting, that recruits to NETS and MedSTAR be educated about the need for efficiency in consulting with clinicians and sharing clinical information with them; and keeping NETS informed about any hitches with the agreed transfer plan.

207. Recommendation 3 proposed by Counsel Assisting is directed at a document *'Model of Care for Paediatric Patients in Far West Local Health District'* [the Model of Care]. This document is intended to provide clarity about lines of responsibility and communication pathways when NETS is providing advice or managing retrievals.

208. At the inquest Dr McCaskill agreed that the Model of Care may need to provide further guidance as to which specialists may need to be consulted in transfer decision making. Recommendation 3 proposes ongoing revision of this document.

209. The proposed recommendations are supported by Austin's family, and are not opposed by any other interested party.

Conclusion

210. On behalf of us all at the Coroner's Court, I express my sincere sympathy to Austin's family for the loss of their much loved little son. They will always grieve for Austin, but I hope that in time their sorrow will ease and that they will find some peace.

211. I thank the outstanding assistance given to the inquest by Counsel Assisting and the Department of Communities and Justice, Legal.

Findings required by s81(1)

212. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Findings:	**Identity of deceased** The person who died is Austin Facer. **Date of death** Austin Facer died on 22 October 2019. **Place of death** Austin Facer died at Broken Hill Base Hospital. **Cause of death** Austin Facer died as a result of cardiopulmonary arrest on a background of earlier cardiac arrests and resuscitations. **Manner of death** The manner of Austin Facer's death is natural causes.

Recommendations

Recommendation 1

To the SCHN, NETS, MedSTAR, the Women's and Children's Hospital Adelaide and the Far West Local Health District:

A. In relation to urgent/critically ill paediatric patient retrieval from Broken Hill Base Hospital to WCHA, that a mutually agreed Guideline be settled between the parties as soon as possible, covering operational and clinical processes for paediatric patient retrieval, including clinical consultation, logistics, bed availability and communication requirements.

B. That the Guideline acknowledge the responsibility of NETS to remain involved and informed in the retrieval process, including up to the point where the relevant MedSTAR retrieval team collects the patient from Broken Hill Base Hospital.

Recommendation 2

To NETS and SCHN:

That work continue on developing a secure method for exchanging a patient's clinical information (including relevant imaging and traces) with involved receiving clinicians, consulting clinicians, and MedSTAR, through the E-referral form and any other appropriate mechanism.

Recommendation 3

To SCHN, NETS and the Far West Local Health District:

That the 'Model of Care for Paediatric Patients in Far West LHD' continues to be revised, including to incorporate guidance on the responsibilities and role of NETS medical and nurse consultants and any other matters of concern.

I close this inquest.

Deputy State Coroner Elizabeth Ryan

Date: 8 December 2022