**CORONERS COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Bridgett Currah |
| **Hearing dates:** | 14,15,16,17 February 2017 at Wentworth |
| **Date of findings:** | 16 March 2017 |
| **Place of findings:** | State Coroners Court, Glebe |
| **Findings of:** | **Magistrate Teresa O'Sullivan, Deputy State Coroner** |
| **Catchwords:** | CORONIAL LAW – Cause and manner of death<br>Dehydration<br>Cyanotic congenital heart disease (CCHD)<br>Gastro-oesophageal reflux disease (GORD)<br>Recording of clinical observations and review notes |
| **File number:** | 2013/159072 |
| **Representation:** | **Mr Jason Downing, Counsel Assisting instructed by James Herrington, Crown Solicitor's Office**<br>**Mr Michael McAuley for the family**<br>**Mr Geoff Gemmell for Mildura Base Hospital and Dr Hariprakash, Dr Kirubakaran, Dr Kuan and Dr Estacio** |

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| **Findings:** | **Identity of deceased**:<br>The deceased person was Bridgett Currah<br><br>**Date of death**:<br>Bridgett died on 22 May 2013<br><br>**Place of death**:<br>She died at 61 Channel Road, Curlwaa<br><br>**Manner of death:**<br>Natural causes<br><br>**Cause of death:**<br>The medical cause of her death was<br>(a) aspiration of gastric contents due to:<br>**(b)** recent gastroenteritis and vomiting leading to an exacerbation of her gastro oesophageal reflux disease (GORD) related vomiting. |
| **Recommendations:** | (i) That nursing and medical staff at Mildura Base Hospital undergo education and training regarding the use of graphical observation and response charts and on the importance of taking and recording standard observations on them;<br><br>(ii) That Dr Kirubakaran undergo education and training as to the importance of making an entry in the clinical notes for each occasion upon which a patient is reviewed and as to who has responsibility for making such entries. |

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*The Coroners Act 2009* (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

*These are the findings of an inquest into the death of Bridgett Currah.*

## REASONS FOR DECISION

# Introduction:

This is an inquest into the death of 19 month-old, Bridgett Currah who died at home after she was discharged from Mildura Base Hospital.

# The Inquest:

This is a discretionary inquest under Sections 21 and 6 of the Coroners Act 2009 (NSW) by reason of Bridgett Currah's death having occurred as a not reasonably expected outcome of a health-related procedure carried out in relation to her.

## *Bridgett's medical history*

Bridgett Currah was born on 14 September 2011 at the Royal Women's Hospital, Melbourne. Bridgett had a complicated medical history. She was born with what is known as cyanotic congenital heart disease (CCHD) with pulmonary atresia, a ventricular septal defect and left pulmonary artery stenosis. In lay terms, Bridgett had complete obstruction of the pulmonary artery which meant that there was a total diversion of blood from the right ventricle of the heart into the aorta. Because of her CCHD, she was transferred to the Royal Children's Hospital, Melbourne shortly after she was born.

Bridgett's CCHD meant that she needed surgery on day five of her life in order for what is known as a Blalock Taussig shunt to be inserted. The purpose of the shunt was to create a connection between an innominate artery and the pulmonary artery so as to provide adequate blood flow to the left pulmonary artery and left lung.

Janet (Jan) Thomas, Bridgett's step-grandmother, recalls that after the shunt was inserted, Bridgett's treating doctors impressed upon the family that it was very important, given her cardiac condition, that she be kept well hydrated. Jan's recollection is that it was explained that if Bridgett became dehydrated, her blood would thicken and it could prevent blood flow and become life threatening. There is expert evidence before this inquest that suggests that children with CCHD indeed have particular vulnerabilities to dehydration. I will turn to that in more detail when I deal with the expert evidence.

The Blalock Taussig shunt procedure was successful but it did not provide a permanent solution to Bridgett's CCHD. When she was five months of age, on 22 February 2012, she required closure of her ventricular septal defect, the creation of a conduit from the right ventricle to the pulmonary artery and repair of the left pulmonary artery. Again, that was performed at the Royal Children's Hospital.

When Bridgett was 13 months of age, on 23 October 2012, she underwent further surgery at the Royal Children's Hospital. That operation was to insert a balloon cathode into her pulmonary artery so as to stent her severe left pulmonary artery stenosis.

Beyond the CCHD, Bridgett had a combination of other conditions which required regular medical management. She suffered from global developmental delay with dysmorphic features suggestive of an underlying genetic syndrome, congenital glaucoma, feeding difficulties with disco-ordinate swallowing and recurrent vomiting thought to be due to gastro-oesophageal reflux disease (GORD). The feeding difficulties meant that Bridgett was fed enterally via a nasogastric tube (NGT) to assist with weight gain for most of her life, until shortly before her death.

## *Bridgett's care:*

Initially, Bridgett was cared for by her biological parents, Emma Page and Andrew Currah. However, on 26 October 2012, after intervention by the Department of Human Services in Victoria, the Children's Court in Mildura made an interim accommodation order removing Bridgett from Emma Page and Andrew Currah's care and placing her into care with her grandfather, Kerry Page (Emma Page's father) and her step grandmother, Jan Thomas.

The evidence before this inquest speaks to the extraordinary care and attention that Jan Thomas in particular provided to Bridgett Currah during her short life. It was Jan who took on the significant burden of managing and coordinating the medical treatment and care Bridgett required.

Jan Thomas kept detailed notes and made detailed diary entries tracking Bridgett's eating and drinking, her more general condition, her day to day behaviour, her medical management and medical and nursing advice that had been provided in respect of Bridgett. Those records are a powerful testament of the lengths Jan Thomas went to in order to help Bridgett to thrive and ensure she was getting the best possible medical care.

From the time Jan Thomas took over Bridgett's care in late October 2012, she took steps to organise the various forms of medical treatment and allied health therapy that Bridgett required. Bridgett had her NGT in place at that time and was having

considerable difficulty with oral feeds. Accordingly, Jan organised check-ups about every 2 weeks with the maternal health nurse in Dareton. She also found a speech therapist, to help Bridgett with her feeding and an occupational therapist to assist with her movement. She organised for reviews by a dietician because of concerns about Bridgett's weight and later, physiotherapy reviews to assist with movement and sitting.

Bridgett was seen and treated by a number of clinicians in both the Mildura area and in Melbourne. She was regularly seen at the Dareton Primary Health Care Centre. She received specialist paediatric care in Mildura from Dr Challam Kirubakaran and Dr Suri Hariprakash. She was also seen at Mildura Base Hospital from time to time for acute admissions and for matters such as the replacement of her NGT.

Bridgett was treated and reviewed at the Royal Children's Hospital, Melbourne from time to time, including for the purposes of the major surgery she underwent for her CCHD.

It is evident from Bridgett's first health record, commonly known as the "blue book", that because of the combination of her conditions and in particular, her feeding difficulties and propensity for vomiting, it was a challenge to deliver adequate feeds to her so that she could increase her body weight, as would be expected, over time. Even though she was being treated with Losec and later, other medications for GORD, her feeding difficulties continued and she often experienced vomiting.

## *Bridgett's feeding issues:*

Bridgett's last significant cardiac review occurred at the Royal Children's Hospital, Melbourne on 13 March 2013. She was 1 year and 5 months old and was assessed by the interventional cardiologist, Dr Eastaugh as being stable from a cardiac point of view. At that point, Bridgett was not displaying any shortness of breath, sweatiness, collapse or unresponsive episodes. However, Bridgett's oral feeding issues were noted, though the NGT remained in place as at 13 March 2013.

Dr Eastaugh did not suggest any particular cardiovascular intervention at that point and simply organised a follow up appointment in 6 months' time in the outpatient's clinic.

Bridgett seems to have pulled out her NGT on the night of 22 April 2013. It so happened that she was due to be reviewed by Dr Hariprakash the next day. By that time, Bridgett had actually been successfully taking her enteral feeds orally for about five weeks. Accordingly, Dr Hariprakash decided not to put the NGT back in and to encourage Janet Thomas to give Bridgett oral feeds. He added Ranitidine (known under the trade name Zantac) to treat her GORD. His plan was to organise a

gastroenterological review and for Bridgett's weight and feeding to be monitored. Dr Hariprakash was concerned as to whether Bridgett would be able to sustain full oral feeds over the longer term.

Following on from the 23 April 2013 review by Dr Hariprakash, Jan Thomas consulted with Bridgett's normal dietician in relation to oral feeds. Consistent with the dietician's advice, Jan diligently ensured that Bridgett got at least 870mls of special formula (known as Pediasure with added MCT oil) each day.

Bridgett's issues with feeding and vomiting continued. When she was reviewed in the Dareton Primary Health Care Centre on 3 May 2013 by Helen Morris, a child and family health clinical nurse specialist, it was noted that she had lost 340 gms over a fortnight following on from the removal of the NGT. When she attended on 17 May 2013 and was again seen by Ms Morris, it was recorded that Bridgett had sustained good weight gain of 280 gms that week (though Jan Thomas' diary entry put the weight gain at 190 gms). Jan also recorded that Bridgett had been eating custards.

Jan Thomas recalled that when she returned home from the Dareton Primary Health Care Centre on 17 May 2013, Bridgett's mother Emma was at the house to visit. Jan emailed Bridgett's up to date weight and height to Bridgett's dietician. Significantly, Jan also recalled that as the day went on, Bridgett became unsettled and was vomiting more than she normally did with her reflux. However, Bridgett still managed to sleep through the night of Friday 17 May 2013.

Bridgett continued to vomit on 18 May 2013. That fact is recorded by a diary entry Jan Thomas made to the effect that Bridgett vomited on her so that she had to have a shower.[1]

Janet's observation during Saturday 18 May 2013 was that Bridgett was vomiting a lot more than normal. She still appeared to be thirsty and to want her bottle, but kept bringing up most of the liquid. Janet pondered whether Bridgett might have some type of virus. Jan's diary entry records a concern about Bridgett's excessive vomiting and thoughts as to whether Bridgett's virus might have come from one of Jan Thomas' other granddaughters, Summah, who had been vomiting on the Thursday.[2]

On Sunday 19 May 2013, Jan Thomas thought Bridgett picked up a bit and appeared more settled and her normal self. She was still vomiting a lot and not wanting food, though she continued to want lots of formula. Bridgett was unsettled when it came to bed time on the night of Sunday 19 May 2013. Jan was concerned about the extent of Bridgett's vomiting and in particular, about the risk that she might

[1] Exhibit 1, Tab 42
[2] Exhibit 1, Tab 42

become dehydrated and what this would mean for Bridgett's cardiac condition and general health.

## *20 May 2013- Bridgett's first visit to Mildura Base Hospital:*

By the very early hours of Monday 20 May 2013, Bridgett was no better, still vomiting excessively and remained unsettled. Jan was concerned enough to take her to the Mildura Base Hospital at about 12.30 am. Bridgett was triaged at 1.12 am and was given triage category 3, meaning urgent – treatment in 30 minutes. Her weight was recorded as 8.5 kgs. The records indicate that Bridgett was dry retching and suffering from episodes of diarrhoea.

Bridgett was initially reviewed by Dr Atheel Badir at 1.33 am. In light of her extensive history and complex constellation of conditions, Dr Badir referred Bridgett to the hospital paediatric team. Dr Lilian Kuan, paediatric registrar on duty at the time, reviewed Bridgett at approximately 2.20 am. Dr Kuan reviewed Bridgett, noted her medical history and recent signs and symptoms and recorded her impression of possible gastroenteritis, possible viral upper respiratory tract infection. She also noted that Bridgett was well hydrated and active.

Dr Kuan discussed Bridgett's condition with Jan Thomas, who agreed to take Bridgett home but planned to return for review at a later time. Jan Thomas' recollection is that the review was to be at noon that day. Dr Kuan's note suggests that the review was to be at noon the following day, though it may well be that because of the hour of the review, Dr Kuan meant noon on 20 May 2013.

Dr Kuan prescribed rectal Panadol and oral Ondansetron. Jan Thomas took Bridgett home and administered the Panadol suppository at about 3 am. Bridgett woke up as normal about 7 am. [3]

## *Communication with Dr Hariprakash:*

There is a dispute on the evidence as to a communication Jan Thomas said she had with Dr Hariprakash by telephone on the morning of Monday 20 May 2013. Jan says that she telephoned Dr Hariprakash in his rooms (though she acknowledged in oral evidence that she could not be sure about that). She says that she told Dr Hariprakash about Bridgett's recent vomiting and diarrhoea and of the fact that she had been seen in the hospital in the very early hours of 20 May 2013. Jan says that Dr Hariprakash indicated that there was no real need to go back to hospital for a review and that rather, Jan should keep up Bridgett's fluids and medication and that she could contact him if need be for further advice.

Dr Hariprakash provided a statement in which he indicated he had no recollection of any such discussion with Jan Thomas. [4] He also indicated that on 20 May 2013, he was working at the Mildura Base Hospital, not in his consulting suites. In his oral evidence, he indicated he wished to correct his statement so as to read that he positively recalled that there was no discussion with Jan Thomas on the morning of

[3] Exhibit 1, Tab 37
[4] Exhibit 1, Tab 22

20 May 2013. He further explained that he simply would never advise to in effect watch and wait as Jan Thomas claims. Dr Hariprakash stated that in Bridgett's circumstances as at 20 May 2013, he would have recommended that she be brought back to hospital.

I find that Jan Thomas did make the call to Dr Hariprakash as she claims. There are essentially two bases for me to reach such a finding. First, Jan Thomas made a diary entry on 20 May 2013 in which she confirmed that she spoke to Dr Hariprakash and set out a basic summary of what she told him and Dr Hariprakash's advice. [5] The diary provides strong corroboration of her version of events. It was never directly put to Jan Thomas that the diary was made with some ulterior motive, such as to support a complaint or claim, though it was suggested that relevant entries may have been made all in one lot, rather than on the dates that they bear. As Jan Thomas' diary and other notes in respect of Bridgett were collected from her by Detective Senior Constable Tanzini on the day of Bridgett's death, it is very difficult to accept that they are anything other than a contemporaneous record of events, made with the intention of keeping track of matters related to Bridgett's health.

Secondly, Dr Hariprakash's evidence is somewhat troubling. He is a busy doctor and no doubt, recalling discussions with patients or patients' carers would be unusual. It is accepted that as he learnt of Bridgett's death on the day it occurred, he had a reason to think about his treating relationship with her, though at that point he was unaware of Jan Thomas' claim about her communications with him on 20 and 21 May 2013. It is hard to understand why he signed a statement on 7 June 2016 indicating that he didn't recall any discussion with Jan Thomas on the morning of 20 May 2013 but then improved his recollection, so as to state in oral evidence that no such discussion ever occurred.

On the balance of probabilities basis, I find that Jan Thomas called and spoke to Dr Hariprakash on the morning of 20 May 2013 as she claims. I hasten to add that no harm befell Bridgett Currah as a result of her not coming in to hospital a second time on 20 May 2013.

Janet Thomas says that she persevered with Bridgett through 20 May 2013, though she remained unwell. Bridgett went to bed as normal and fell asleep on the night on Monday 20 May 2013.

There was a further dispute on the evidence as to a message Jan says she left for Dr Hariprakash on the morning of 21 May 2013. Jan says that she left a message for Dr Hariprakash in his rooms to indicate that there was no change in Bridgett's condition. Jan says she was hoping Dr Hariprakash would see Bridgett. She says that she never got a call back.

Dr Hariprakash indicated in his written statement that he did not recall receiving any message about Jan Thomas trying to contact him or any voicemail from her. In his oral evidence, he changed that version to indicate that he positively recalled that he received no message or voicemail.

[5] Exhibit 1, Tab 42

Again, Jan Thomas has a diary note to the effect that she called Dr Hariprakash's rooms and left a message to call back. Dr Hariprakash confirmed in his evidence that his rooms were open, with someone present to take messages, from 9 am. Jan Thomas' evidence was that by about 1 pm, she got impatient about having Bridgett seen so she decided to take her to the ED at Mildura Base Hospital, having not heard back from Dr Hariprakash.

Again, for the same reasons in respect of the disputed conversation on 20 May 2013, I find, on the balance of probabilities, that Jan left a message for Dr Hariprakash on the morning of 21 May 2103. It is ultimately not possible to know what became of the message. Further, it is not suggested that any harm befell Bridgett because of the fact that Dr Hariprakash did not get back to Jan Thomas. Jan took Bridgett in to hospital at around 1 pm.

## *21 May 2013-Bridgett's second visit to Mildura Base Hospital:*

Jan Thomas was concerned that Bridgett remained unwell and ultimately, took her to Mildura Base Hospital at about 1.00 pm. The records from Mildura Base Hospital indicate that Bridgett was triaged at approximately 1.50 pm and given a triage category of 5, meaning non-urgent. Bridgett's weight was initially recorded at 8.5 kgs, though ED medical notes made at 3.32 pm put the weight at 7.8 kgs. An entry in the ED Observation Chart, seemingly made at about 4.10 pm, also puts Bridgett's weight at 7.8 kgs. On the evidence before me, I find that Bridgett's actual weight on 21 May 2013 was 7.8 kgs, with the initial recording of 8.5 kgs in the ED medical notes that day simply being a copying over of her weight from the previous day. [6] It is known that the 20 May notes were obtained and made available to hospital staff on 21 May 2013. On the evidence it appears that Bridgett's weight had dropped approximately 700 gms, even allowing for a small margin for error.

There is no dispute that at approximately 4.30 pm, Bridgett was reviewed by Dr Estacio, hospital medical officer and Dr Kirubakaran, consultant paediatrician. Dr Estacio wrote up the entirety of the notes for that review of Bridgett. Whereas Dr Kirubakaran suggested that it was she who took the history and performed the examination, with Dr Estacio simply scribing. Dr Estacio's evidence suggested that she in fact performed her own examination of Bridgett, at least in part. I find this to be the more likely scenario, noting in particular that the examination recorded in respect of the abdomen does not indicate any faecal masses, whereas Dr Kirubakaran was adamant that she identified them during her examination of Bridgett, leading to her diagnosis of constipation. Dr Estacio indicated that this was not a diagnosis she arrived at, though she deferred to Dr Kirubakaran as the more senior clinician.

Both Dr Estacio and Dr Kirubakaran confirmed that they had access to and in fact read the notes of Bridgett's 20 May 2013 attendance. I find that the diagnosis Dr Kirubakaran reached of constipation was an unlikely one on all of the available clinical evidence. Whilst it seems that Jan Thomas gave a history of Bridgett last opening her bowels five days ago during the 4.30 pm review, that stood in contrast to

[6] Exhibit 1, Tab 37

the history Dr Kuan recorded the day before. Further, the examinations performed by Dr Kuan and Dr Estacio were against a finding of constipation.

It is not in dispute that Bridgett Currah was dehydrated to some degree as at the 4.30 pm review on 21 May 2013. According to her statement, Dr Kirubakaran concluded that Bridgett was mildly dehydrated. [7]The extent of the dehydration at the time was the subject of expert evidence and will be dealt with below. I find that at 21 May 2013 dehydration was moderate given Bridgett's weight loss, the fact that according to the history recorded by Dr Estacio there was a reduction in the number of wet nappies she was producing, the fact that she had dry mucus membranes and the evidence of tachycardia. The evidence indicates that whereas Bridgett's normal heart rate was around the 100 to 120 mark (slightly higher than the normal for a child without Bridgett's comorbidities) it was significantly increased on 21 May 2013, with the range being between approximately 140 and 165 (and with one reading of 192 beats per minute).[8]

Relevantly, the plan of management recorded in the notes for Bridgett by Dr Estacio at approximately 4.30 pm was to treat her with half a fleet enema and intramuscular injections of Ondansetron as required. There is no doubt that this was the plan Dr Kirubakaran settled upon. Bridgett was accordingly treated with a half fleet enema at approximately 5.25 pm and an intramuscular injection of Ondansetron at approximately 6.15 pm.

There is an issue as to whether Dr Kirubakaran also concluded that Bridgett needed to be admitted at 4.30 pm. There is no mention of that in either the notes or Dr Kirubakaran's statement. However, in Dr Estacio's statement of 6 January 2013 and her oral evidence, she indicated that Dr Kirubakaran decided upon admission during that initial 4.30 pm review.[9]

On the evidence, it seems likely that Dr Estacio is mistaken. The evidence tends to a finding that Dr Kirubakaran wanted Bridgett to be treated in hospital with the half fleet enema and Ondansetron and then observed with a view to possible discharge, rather than that she had decided upon admission at 4.30 pm. Further, no logistical/administrative steps were taken after 4.30 pm to organise a bed for Bridgett. That suggests that Dr Estacio's recollection of events is imperfect.

The nursing entries indicate that after the half fleet enema was given, Bridgett initially passed a small pebble like stool (by approximately 7.10 pm) and then had a very large bowel action between 7.10 pm and 7.45 pm. It also indicates that after the IM Ondansetron was given, Bridgett managed to drink a full cup of approximately 200 mls of milk (formula) with no subsequent large vomit, though small posits, typical of what Bridgett normally experienced.

[7] Exhibit 1, Tab 20
[8] Exhibit 1, Tab 37
[9] Exhibit 1, Tab 18

## *Bridgett's discharge from Mildura Base Hospital:*

Dr Estacio made an entry at 7.50 pm indicating that she returned to review Bridgett. Notwithstanding that there is no mention of Dr Kirubakaran reviewing Bridgett at about that time in Dr Estacio's entry in the notes, that Dr Kirubakaran made no entry in the notes herself and that there is no mention of any review by Dr Kirubakaran at about this time in the two statements of Dr Estacio, both doctors gave oral evidence that Dr Kirubakaran in fact came back and reviewed Bridgett prior to her discharge.

In her 18 December 2013 statement, Dr Kirubakaran claimed that she returned and reviewed Bridgett at approximately 7.30 pm. Jan and Tiffany Thomas gave contrary evidence, stating that Dr Kirubakaran did not return. Jan Thomas recalls Dr Estacio telephoning Dr Kirubakaran at about 8.00 pm and then relaying to Jan that Dr Kirubakaran had cleared Bridgett for discharge.

I find that Dr Kirubakaran did not in fact return to review Bridgett at around 7.30 pm – 7.50 pm and that instead, Dr Estacio reviewed Bridgett herself and then telephoned Dr Kirubakaran.

I prefer the evidence of Jan Thomas and Tiffany Thomas to that of Dr Estacio and Dr Kirubakaran for the following reasons. First, there is the fact that, very unusually, the available written records weigh strongly in favour of the family's version of events, rather than the doctors' version of events. Whereas typically medical records are relied on by doctors to refute oral evidence that family members give without any corroborating documents, the entry Jan Thomas made in her diary on Tuesday 21 May 2013 refers to Bridgett responding to the injection of Ondansetron and Dr "Marni" then calling "Challam" and sending Bridgett home. [10]

The unchallenged evidence is that Jan Thomas made that entry on 21 May 2013. On the other hand, Dr Estacio made no reference to Dr Kirubakaran being present and reviewing Bridgett leading up to her discharge. That stands in contrast to the entry Dr Estacio made at 4.30 pm, when she recorded the words "reviewed by Dr Challam". That of itself suggests, by reference to Dr Estacio's practice of record making, that Dr Kirubakaran was not present at about 7.50 pm.[11]

Secondly, Dr Estacio made no mention of Dr Kirubakaran returning to review Bridgett for a second time in her statement of 6 January 2013 or her supplementary statement of 10 August 2016.[12] It is unlikely that Dr Estacio would not mention Dr Kirubakaran returning and reviewing Bridgett and discussing her discharge with Jan Thomas in either of those two statements if it in fact occurred. Dr Estacio was aware that there was a coronial investigation looking into the circumstances of Bridgett's death and the adequacy of the care and attention Bridgett received at Mildura Base Hospital. No doubt, she would have wanted to indicate that Dr Kirubakaran, a consultant paediatrician, had reviewed Bridgett just before discharge if that was the fact (noting that Dr Estacio was a HMO with no paediatric specialty). That she went to the trouble of putting on a supplementary statement in order to correct some small errors in her first statement and add further information to it, without so much as

[10] Exhibit 1, Tab 42
[11] Exhibit 1, Tab 37
[12] Exhibit 1, Tab 18

mentioning Dr Kirubakaran returning to review Bridgett Currah at about 7.30 – 7.50 pm, tends strongly towards my finding that no such return and review occurred.

Thirdly, there was a fairly significant discrepancy between the evidence of Dr Estacio and Dr Kirubakaran as to the circumstances of the alleged second review at about 7.30 – 7.50 pm. Whereas Dr Kirubakaran claimed that she and Dr Estacio were both present for the entirety of the review and that Dr Estacio wrote all of the notes, Dr Estacio stated that she returned at about 7.50 pm, spoke to Jan Thomas and performed an examination and was then called away to attend to another patient in the ED, at which time Dr Kirubakaran happened to appear and in effect took over the review. That is a fairly significant detail for the two doctors to disagree on and again, provides a basis upon which to have real doubts as to whether Dr Kirubakaran in fact returned.

Fourthly, it is difficult to accept that Dr Kirubakaran would simply make no note at all if, as she claims, she spoke to Jan Thomas, advised her that Bridgett needed to be admitted and Jan Thomas indicated that she was not prepared to go along with that advice. Notwithstanding Dr Kirubakaran's suggestion that this was not a situation of discharge against medical advice, it was plainly a case of Jan Thomas insisting on leaving the hospital contrary to Dr Kirubakaran's advice, which brought it squarely within the Ramsay Health Care policy on Discharge at Own Risk Against Medical Advice.[13] Dr Kirubakaran conceded that her advice that Bridgett should be admitted never wavered, despite Jan Thomas' indication that she wanted to take Bridgett home.

Even if Dr Kirubakaran didn't see fit to complete the Discharge at Own Risk Form, which she should have, one would reasonably have expected that she would have made some reference in the notes to her urging admission and Jan Thomas not being prepared to go along with the advice.

On the evidence before me I find that after Dr Estacio returned and reviewed Bridgett at about 7.50 pm and spoke to Jan Thomas, she telephoned Dr Kirubakaran, described that Bridgett's vomiting had settled down after the Ondansetron and that she had had a large bowel action after the half fleet enema. I find that Dr Kirubakaran told Dr Estacio that Bridgett was appropriate for discharge and that Dr Estacio conveyed this to Jan Thomas.

Dr Estacio has recorded in her notes "mother happy to go home" and has confirmed in her evidence that this was a reference to Jan Thomas. I find that Jan Thomas did not request that Bridgett go home and in fact, fully expected that Bridgett would be admitted to hospital. Jan's belief in that regard is supported by her evidence and Tiffany Thomas' evidence that Jan called Tiffany and had her bring Bridgett's clothes and formula into hospital (at around 6.00 pm). That evidence was not seriously challenged.

Dr Estacio's notation about the "mother" being happy to go home likely reflects the fact that Jan Thomas did not protest when the decision about Bridgett being discharged was conveyed to her by Dr Estacio. Jan has indicated that she accepted

[13] Exhibit 1, Tab 45

what she was told, partly because she knew that Bridgett would likely sleep better at home and also, because she trusted the doctors' judgment. Nonetheless, there is a significant difference between Jan Thomas not pushing back to challenge the doctors' decision to discharge Bridgett and Jan Thomas actually requesting discharge.

Tiffany Thomas gives evidence of reacting angrily to a nurse conveying the decision to discharge Bridgett home. It is not clear who the nurse was but ultimately, Tiffany Thomas' evidence does not detract from or in any way contradict Jan Thomas' evidence.

I accept, as per Dr Estacio's 7.50 pm entry in the notes, that she gave Jan two extra doses of Ondansetron to give to Bridgett overnight and advised her that she should return Bridgett for review at 11.30 am in the morning. Bridgett was discharged and as per the notes Dr Estacio made in the records under the heading "Discharge Advice", it is accepted that she advised Jan Thomas that she should bring Bridgett back if her vomiting reoccurred.

## *The evening of 21 May 2013:*

Jan Thomas then took Bridgett home and Bridgett remained unsettled during the evening. She drank her formula and seemed very thirsty. It seems that Bridgett had small posits when she drank her formula, consistent with the type of vomiting she typically experienced. Jan checked in on Bridgett at about 11.30 pm and she had settled by that time in her cot. She was asleep on her back and Jan did not observe any vomiting or notice any abnormality with Bridgett's breathing. Jan Thomas then went to bed.

## *22 May 2013:*

The evidence indicates that soon after 5 am on 22 May 2013, Jan Thomas went in to check on Bridgett. She found her lying on her back with her eyes open and a small amount of froth around her mouth. She called 000 at approximately 5.10 am and commenced CPR as she was advised. Bridgett was not breathing and Jan identified a large amount of vomit in her mouth. As the 000 operator advised, Jan did her best to get the vomit clear and do CPR.

Ambulance officers attended the scene at 5.23 am. They found Bridgett to be cold to touch with dependent lividity and no vital signs. They assessed that Bridgett was deceased.

On the basis of Jan's observations when she checked in on Bridgett early on 22 May 2013, the observations of the ambulance officers and the autopsy report, I find that Bridgett Currah died on the morning of 22 May 2013 after vomiting and then aspirating her gastric contents. It seems likely that she had been suffering from a recent acute bout of gastroenteritis and vomiting, which led to an exacerbation of her normal GORD related vomiting.

## *Expert Evidence and Contentious Issues Regarding Bridgett's Management*

In light of the reports and oral evidence from experts, Dr Lubitz and Dunlop, consultant paediatricians and Dr Stormon, consultant paediatric gastroenterologist, I make a number of findings regarding Bridgett's condition and the adequacy of her care and management.

It is uncontentious that because of her constellation of conditions and in particular, her cyanotic congenital heart disease, Bridgett was more vulnerable to the effects of dehydration than other children. That was because of her reduced reserve to handle episodes of dehydration and the risk of thrombotic complication (which could have catastrophic results in light of her cardiac condition).

On any view, the observations done whilst Bridgett was in hospital were inadequate. The expert evidence supports the finding that they should have been done hourly from about 2 pm when Bridgett arrived through to her discharge. Instead, a reduced range of observations were done at 4.30 and 5.25 pm. A single respiratory rate was done at 7.10 pm and no further observations were done at all through to Bridgett's discharge at between 7.45 pm and 8 pm. The evidence from Dr Lubitz and Dr Dunlop was to the effect that in a child with Bridgett's background conditions who had an acute illness resulting in increased vomiting and a significant weight loss (approximately 8% of her body weight over about 36 hours) standard observations had an important role to play in assessing Bridgett's condition and deciding on her further management.

In Bridgett's particular circumstances on 21 May 2013, blood tests and blood gases should have been performed. Dr Dunlop was unequivocal about that. Dr Lubitz suggested that there were more shades of grey, but ultimately conceded that in Bridgett's particular circumstances and with objective evidence of moderate dehydration, blood should have been taken for testing.

The result of doing neither observations nor bloods in the period leading up to Bridgett's discharge is that those caring for Bridgett were left with only very subjective signs of her condition/progress, with little objective information to assist and guide them.

Finally and most significantly, when one has regard to the totality of Bridgett's history and signs and symptoms by the early evening of 21 May 2013, she should have been kept in hospital for overnight observation. In particular, where she was fragile and vulnerable because of her various comorbidities including her cyanotic congenital heart condition, she generally had feeding difficulties and difficulty keeping on weight, she had a recent acute bout of vomiting, the history on 21 May 2013 was that she was producing less wet nappies than normal and she had lost 700 gms over about a day and a half, there was a compelling case for Bridgett to be admitted to hospital. She also had an unexplained tachycardia, an increased thirst, grizzliness/altered mentation and she had been brought to hospital twice in two days, indicating considerable concern on the part of Jan Thomas, her experienced carer.

I do not accept that it is only in retrospect that there was a need for admission. Dr Lubitz accepted that unless Bridgett's carer was actively requesting discharge (in which case it would be a more difficult decision) Bridgett should have been admitted in light of the totality of her circumstances. Whilst there may have been some limited subjective evidence of improvement in Bridgett's condition as at 7.45 pm, in that she had drunk 200 mls of formula with only small posits, that was but one factor in what was overwhelmingly still a concerning presentation (and only a very short time has passed since Bridgett drank the 200 mls). As both Dr Kirubakaran and Dr Lubitz agreed, the great advantage of hospital admission is that patients can be regularly monitored and observed and trends can be detected over time. Doctors and nurses are more skilled than lay people in assessing patients' well-being and in a patient like Bridgett, an oxygen saturation monitor could be used in order to immediately alert those caring for Bridgett of desaturations, as would occur if, for example, an episode of aspiration occurred.

It is also significant that because the discharge occurred at about 8 pm at night, it was always likely that Jan Thomas would go to bed at some point and thus not be in a position to observe Bridgett and monitor her in the same way that would occur in hospital. Dr Lubitz agreed with this proposition.

In light of Dr Dunlop's oral and written views and the fairly significant concessions Dr Lubitz made in oral evidence, I find that Bridgett should have been admitted on the evening of 21 May 2013. Whilst it is not suggested that one could prospectively anticipate that Bridgett would aspirate vomitus, it was one risk, from a range of risks she faced if she went home. Because of her fragility and vulnerability and the evidence of moderate dehydration, she faced real, appreciable risks of morbidity and mortality which would have been best managed in a hospital setting.

I would like to thank the officer in charge, detective senior constable Mark Tanzini for his thorough investigation.

In closing, I would also like to thank my counsel assisting, Jason Downing for his assistance throughout the inquest and for his excellent submissions that I have largely adopted in my findings. I would also like to thank his instructing solicitor, James Herrington from the Crown Solicitor's Office for his excellent work.

Finally, I offer my sincere condolences to Bridgett's family. It is clear that Bridgett received much love and care during her short life.

## Recommendations

During the course of this inquest it is evident that there were deficiencies in record keeping, the taking of observations and the performance of reviews by senior clinicians prior to discharging Bridgett Currah. Mildura Base Hospital has introduced new paediatric specific graphical observation and response charts since Bridgett Currah's death but Dr Kirubakaran's evidence indicated that she was unaware of them. She was aware of a new patient management system incorporating an electronic medical record had been introduced, though she indicated that she had no experience with it or knowledge of how it worked.

I have had regard to the Supplementary Submissions filed on behalf of Mildura Base Hospital, in respect of possible recommendations, dated 6 March 2017 and the various background documents referred to in them and attached to them. I note that the Hospital resists the two recommendations suggested by counsel assisting in his written and oral submissions.

With respect to the proposed recommendation that nursing and medical staff at the Hospital undergo education and training regarding the use of graphical observation and response charts and on the importance of taking and recording standard observations on them, I note that the evidence before me suggested not a one off failure to record standard observations, but a fairly consistent failure to record any or proper observations through the 21 May 2013 admission. While I accept that it is not a pattern of failing to record observations over days or months, it is nonetheless significant and concerning.

I also note that the Hospital, in its Supplementary Submissions, places significant emphasis on training and education provided to its staff in respect of the recognition and escalation of clinical deterioration. I point out that properly understood, Bridgett's presentation on 21 May 2013 was not a case of clinical deterioration which was not picked up. Rather, Bridgett was a child who was already vulnerable and fragile because of her various comorbidities and presented with a serious acute condition. She was only kept in hospital and observed/monitored for a relatively short period of time. Thus, I am not persuaded that education and training in respect of recognition and escalation of clinical deterioration is directly relevant to the key issues before me. I do however acknowledge that a number of the training and education documents the Hospital has provided cover the importance of recording observations in observation and response charts, albeit in the context of a clinically deteriorating patient.

I also note that notwithstanding the various documents which the Hospital has provided, including audit documents showing a significant improvement in the compliance with completion of the observation and response charts, none of this material was tested or examined in Court. I make no criticism, but it does make it more difficult to be satisfied that current practices at the Hospital with respect to taking and recording observations, are noticeably better than they were as at 21 May 2013.

With respect to the proposed recommendation that nursing and medical staff of the Hospital undergo education and training as to the importance of making an entry in the clinical notes for each occasion upon which a patient is reviewed and as to who has responsibility for making such entries, I accept the Hospital's submission that the available evidence points to entirely adequate entries being made in the notes on 20 May 2013 by Dr Kuan. Further, I accept that none of the other hospital records in respect of Bridgett's presentations to the Hospital (and there were many) were reviewed or analysed so as to suggest deficiencies in the making of entries by treating doctors in respect of the reviews they performed.

I accept that the evidence before me does not go so far as to suggest a systemic problem in nursing and medical staff at the Hospital making entries in the clinical notes for each occasion upon which a patient is reviewed. In the circumstances, I

am persuaded that education and training as to the importance of making an entry in the clinical notes for each occasion upon which a patient is reviewed and as to who has responsibility for making such entries should properly be limited to Dr Kirubakaran, rather than the entire medical and nursing staff at the Hospital. I note that Dr Estacio is in fact no longer practicing as a doctor and no longer works at the Hospital.

Arising from the above, I consider it appropriate to make recommendations to Ramsay Health Care, the operator of Mildura Base Hospital, as follows:-

(i) that nursing and medical staff at Mildura Base Hospital undergo education and training regarding the use of graphical observation and response charts and on the importance of taking and recording standard observations on them;

(ii) that Dr Kirubakaran undergo education and training as to the importance of making an entry in the clinical notes for each occasion upon which a patient is reviewed and as to who has responsibility for making such entries.

## Findings required by s81(1)

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.

### *The identity of the deceased*

The deceased person was Bridgett Currah

### *Date of death*

Bridgett died on 22 May 2013

### *Place of death*

She died at 61 Channel Road, Curlwaa

### *Cause of death*

The medical cause of her death was

(a) aspiration of gastric contents due to:

(b) recent gastroenteritis and vomiting leading to an exacerbation of her gastro oesophageal reflux disease (GORD) related vomiting.

### *Manner of death*

Natural causes

I close this inquest.

**Magistrate Teresa O'Sullivan**
**Deputy State Coroner**

**Date 16 March 2017**