[redacted] and [redacted]
[redacted]
[redacted]
[redacted]

[redacted] 2022

Northern Health
Patient Experience Office
185 Cooper Street, Epping 3076

By email only: [redacted]

To whom it may concern,

Complaint to Northern Health

1. We are writing to complain about the conduct of Dr [redacted], acting as Paediatric Consultant at Northern Health. We believe Dr [redacted] grossly mismanaged the care of our son, [redacted], between [redacted] 2021 and [redacted] 2021. This complaint extends to how Dr [redacted] treated us, [redacted] parents.

2. [redacted] was [redacted] months old at the time.

3. The gross mismanagement of the care of [redacted] is outlined in detail in our chronology at **Annexure A.**

4. By way of summary, the gross mismanagement included the following:

    a) Services of an Aboriginal Liaison Officer or social worker were not made available despite [redacted] being visibly distraught.
    b) Unnecessarily exposing [redacted] to full body X-ray screening, an experience he found distressing and uncomfortable.
    c) Unnecessarily exposing [redacted] to X-ray screenings without protective gear.
    d) Putting [redacted] arm in the wrong cast early in the healing process, potentially delaying or hindering healing of the injury, and not communicating adequately about this.

e) No information was given on why [redacted] was not given blood tests to assess for an underlying condition, given [redacted].

f) At no time was [redacted] taken to ED Paediatrics. All interaction with hospital staff and treatment was provided in either the Northern Health internal ED wait area, or the external, COVID wait area.

g) Dr [redacted] did not provide a discharge summary. No out-patient appointment or formal plan for follow up care was provided.

h) Dr [redacted] contacted [redacted] (patient's mother) at an inappropriate time (10:03pm on a Sunday night) and did not clarify if [redacted] health was in immediate risk. Dr [redacted] lied to the mother about Child Protection's involvement and the need to re-present to the hospital. Dr [redacted] also used inappropriate emojis in text messages.

i) Dr [redacted] said that he believed [redacted] was at risk of harm because his father "ticked too many boxes". Dr [redacted] made these inappropriate comments to the patients' mother despite the fact that Child Protection had refused to raise a case on [redacted] 2021.

j) Dr [redacted] lied and manipulated parents into believing that a case had been raised with Child Protection, and that [redacted] was to be removed from their care, when in fact Child Protection had refused to raise a case due to Dr [redacted] claims lacking merit.

k) In covering for the breaches in processes and protocol of Dr [redacted] we were wrongly led to believe for weeks following, that at any moment, our child could be removed from our care.

l) Dr [redacted] also made false statements in relation to a Child Protection case.

m) [redacted] was later subjected to unnecessary invasive and distressing medical tests and monitoring at Northern Health, Epping.

n) The parents were not made aware of proper processes regarding the reporting of non-accidental injuries to Child Protection, including the role of VACCA.

o) Given that there was no case with VACCA or Child Protection, the family were not offered support and advocacy services usually provided by these agencies during this process.

5. We believe that the actions taken by Dr [redacted] demonstrate that current systems, processes and protocols set in place at Northern Health are inadequate in protecting families from abuses of power by staff who are in positions of authority. For example, our experience demonstrates:

a. That there are multiple ways staff can falsify or omit records and mislead and manipulate patients and their carers.

b. That there are ongoing systems of prejudice within the hospital, which allow those in positions of power to engage their own bias to render Aboriginal families vulnerable to the unnecessary involvement of Child Protection.

c. That there is a lack of sufficient processes and protocols set in place at the hospital to protect families from the bias of doctors, which then lead to negligence, mismanagement and harm caused to children and parents.

6. As a result of the matters outlined at paragraphs 4 and 5.

a. [redacted] experienced distress and discomfort from unnecessary medical treatments, and errors may have delayed or hindered the healing of his injuries.

b. Both parents were left fearful of the hospital system and are since extremely reluctant to return to its care.

c. Both parents are receiving psychological support for anxiety caused and ongoing fear and mistrust of doctors.

d. Both parents are reluctant to declare their children's Aboriginality to any government institution for fear of subsequent personal bias and further abuses of power by those in positions of authority.

7. We ask Northern Health to action the following by way of redress:

a. Conduct a full and thorough investigation into the actions of Dr [redacted] in relation to this case.

b. Conduct a full and thorough review of prior Child Protection cases raised by Dr [redacted]

c. Provide a written apology to the patient and his family.

d. Provide reimbursement for ongoing psychological care of parents and private paediatric care of [redacted].

e. Conduct a review of protocol and process for the reporting of non-accidental injuries, medical histories and discharge summaries.

f. Review the purpose and role of Aboriginal Liaison Officers

g. Review processes set in place for informing parents of a child protection case. Parents are to be informed at the time of reporting and linked immediately to support such as VACCA, VAHS, VALS and other services before leaving Northern Health, after verification of a case raised.

8. We also ask Northern Health to implement the following recommendations:

a. Aboriginal Liaison Officers are to be on hospital grounds and available 24 hours a day, seven days a week. This is to be advertised widely within the hospital across all departments, as well as explicitly explained to all staff, and patients of Aboriginal or Torres Strait Heritage.

b. Social Workers of First Nation's heritage are to be employed as a priority.

c. Implement staffing quotas for doctors, social workers and nurses of First Nation's heritage as a matter of urgency.

d. Protocols and processes in relation to the care of Aboriginal and First Nations individuals and families and reporting to Child Protection are to be reviewed as a matter of urgency in close consultation with Victorian Aboriginal Child Care Agency, Victorian Aboriginal Health Services and Victorian Aboriginal Legal Service.

e. Hospital staff are to call from a phone that identifies as NORTHERN HEALTH. Do not call from a private line, or an unidentified number. Expecting parents to respond to a private or unknown mobile number is not fair or reasonable and is not a trauma-informed approach to healthcare.

f. Hospital staff are to consider the timing of phone calls. Expecting that parents will answer at 10pm on a Sunday night is not fair or reasonable.

g. In all correspondence, clearly articulate the level of urgency, the required action from parents and who to contact. Do not use or state emotive language, personal judgments or emojis.

h. Staff members are never permitted to mislead or manipulate patients or their carers through fear or any other means.

i. Staff who mislead or manipulate patients, parents or carers through fear or any other means should be investigated, stood down and referred to government bodies for suspension or cancellation of their licence to practice.

j. Children are to be admitted and treated within the paediatrics ED or ward, not in the waiting room. If for some reason there is no option other than the waiting room, this needs to be explained to the parents, must not impact the level of care received by the patient and

should not put their parent or carer at risk. [redacted] age does not allow him the opportunity be vaccinated against Covid-19. This must be taken into account in treating children.

k. If parents are required to hold children undergoing X-ray examination, then the proper lead covering is to be provided.

l. Attending doctors are to refer to and always follow Victorian Forensic Paediatric Medical Service (**VFPMS**) guidelines.

m. Refer to VFPMS guidelines when informing parents of mandatory reporting to Child Protection. Show parents the website, charts and explain processes, protocol and next steps.

n. A social worker, Aboriginal Liaison Officer or advocate should be made available to parents, carers and children in ALL cases of suspected non-accidental injury, regardless of time or day of presentation.

o. Mechanisms of injury are to be recorded at the time of being described by parents, then the written record is to be reviewed at that time, until the patient or their carer is satisfied it has been recorded correctly.

p. All patients and their carers are to be provided with a paper or electronic copy of the discharge summary before they leave the hospital.

q. All patients and their carers are to be provided with a paper or electronic copy of a detailed injury care plan before they leave the hospital.

r. Both the discharge summary and injury care plan are to be reviewed by patient and/or carer prior to discharge and amended as necessary. Any ongoing concerns raised by parents are to be noted on the patient file.

9. Please respond to this complaint within **30 days** by return email to [redacted] and [redacted]

10. We reserve our rights, including (but not limited to) escalating our complaint to the Health Complaints Commissioner, reporting Dr [redacted] to the Australian Health Practitioner Regulation Agency and pursuing legal action.

Yours sincerely,

[redacted] and [redacted]

Complaint-Northern Health [redacted] [redacted]

Annexure A - Chronology

Date	Time	Event	Complaint
Tuesday [redacted] 2021	Approx. 5:45pm	• [redacted] (**Patient**) injured his arm at home, while in the care of his father, [redacted] (hereafter **Father**) and his mother [redacted] (hereafter **Mother**). • The Father took the Patient from the bath to the bed to dry and dress him. In transit from the bath to the bed, the Patient was happy, giggling and playing with his father. • As the Father placed the Patient onto the bed to be dressed, he was throwing his arms and legs around happily. The Patient then thrusted back and outstretched his arms behind him. His left arm became sandwiched between the bed and his body as he grabbed hold of the sheet underneath him. • After noticing the position of the Patient's forearm, and the way it was bent, the Father released the Patient's hand from the sheet. The Patient then straightened his arm out and began to cry as if annoyed and irritated.	• No services of Aboriginal Liaison Officer or social worker made available despite Father being visibly distraught. • Father was not supplied protective gear during X-ray. • At no time was Patient taken to ED paediatrics. All interaction with hospital staff and treatment was provided in either the Northern Health internal ED wait area, or the external, COVID wait area. • Dr [redacted] did not provide a discharge summary. No out-patient appointment or formal plan for follow up care was provided. • The father was not made aware of proper processes regarding the reporting of non-accidental injuries to Child Protection, including the role of VACCA.
	Approx. 5:47pm	• The Father dialled 000, put a nappy on the Patient and comforted him while holding him in a blanket. • The Father then alerted the Mother and waited for 000 to answer while holding the Patient in a blanket. • There was a delay in Ambulance Victoria's (**AV**) attendance, so the parents decided to transport [redacted] to Northern Hospital themselves.	
	Approx. 6:45pm	• AV arrive as the Patient is being placed in car to be driven to hospital. AV advises parents to continue to hospital	
	Approx. 7:30pm onwards	• The Father and Mother arrived at the hospital. • Seen by triage nurse, directed to wait next to triage desk and later directed to wait in a room next to Covid-19 testing area within ED triage building. • The Father was wearing clothing that included Aboriginal artwork or designs on it.	

		• The Father was asked by hospital staff if he is Aboriginal and he confirms that he is. • The Father requested pain medication for the Patient which was provided by nurse. • Dr [redacted] saw the Patient in the triage waiting area and conducted a brief assessment with instruction that an X-ray was to be conducted. • Shortly after, the Father and Patient were approached by an X-ray practitioner and escorted to a room/area adjacent to an exit from the ED waiting area to the main building of the hospital. • Two people conducted the X-ray with the Father holding the Patient seated. • Once the X-ray was complete the Father was directed back to the triage building waiting area next to the Covid-19 testing area. • Dr [redacted] applied a backslab cast in the internal ED waiting area. • Dr [redacted] asked the Father what happened. The Father describes mechanisms of injury. Dr [redacted] made it clear he didn't believe the Father and informed that the injury patient sustained was considered by Dr [redacted] to be non-accidental. After this, Dr [redacted] interrogated the Father regarding his life and lifestyle. • The Father asked about care for the cast and about future appointments or scans that need to be done. Dr [redacted] explained general care for the cast and recommended the Father take the patient to GP in 'a couple weeks'	
Wednesday [redacted] 2021	1:30am	• Mother calls Northern Health shortly after the Patient and Father return home. Patient settled; Father distraught and unable to explain to Mother what had happened at the hospital, follow up care etc. • Seeking advice on follow up care for the patient, Mother calls Northern Health and speaks firstly to a Paediatric nurse on ward, before being transferred to Dr [redacted] in ED.	• No information given on why patient was not given blood tests to assess for an underlying condition, given [redacted]. • No information given why full cast not placed on patient. • No outpatient appointment made.

		• The Mother asks why, given the [redacted], blood tests to assess for an underlying condition were not conducted. The Mother queries why a full cast was not placed on the Patient. • The Mother queries why Child Protection was alerted. Mother queries why father was not sent home with a discharge summary. The Mother queries why an outpatient's appointment for [redacted] was not required. • Dr. [redacted] reassures Mother that a backslab caste was sufficient for a 'greenstick' fracture. • Dr [redacted] falsely tells the Mother that a Child Protection case was raised as the injury triggered a mandatory reporting response, due to the Patient's age and nature of the break. This was later found to be incorrect. (Green stick fractures do not trigger mandatory reporting and Child Protection and VACCA had agreed that there was insufficient cause to raise a case, given the Father's behaviour and the described mechanisms of the injury. NO CASE with Child Protection was made at this time). • Dr [redacted] is unable to provide information, or explain why blood tests were not conducted, or why an outpatients' appointment was not made. • Dr [redacted] informs mother that Dr [redacted] had not prepared a discharge summary, but that one will be sent to the GP on file, within a few days. • Dr [redacted] advises the mother to take the Patient to the GP in 'a week or two" for follow-up care.	• Dr [redacted] did not prepare a discharge summary. • Dr [redacted] made false statements re: Child Protection case.
	9:15am	• The Mother contacts Aboriginal Liaison Officer, [redacted] Explains happenings to date. Mother again requests a discharge summary and outpatients' appointment. • [redacted] speaks with staff at Northern Health and organises for a discharge summary to be posted.	
Sunday [redacted] [redacted] 2021	10:03pm	• Mother receives the following text message to her mobile phone after missing a call from Dr. [redacted] *Hi* [redacted] *its Dr* [redacted] [redacted] *I*	• Dr [redacted] made these inappropriate comments to the Patients' Mother

		was the consultant paediatrician in charge when your son [redacted] presented with an injury to his arm at the Northern on the [redacted]. I was hoping to have a chat with you ASAP as we need to get him to present back to ED to organise some further scans. Please • To the mother's knowledge, it is the first and only attempt at correspondence between Mother and Dr [redacted] Mother does not see this message as she was asleep at the time.	despite the fact that Child Protection had refused to raise a case on [redacted]. • Dr [redacted] used inappropriate emojis in text messages. • Dr [redacted] contacted mother at an inappropriate time and did not clarify if Patient's health was in immediate risk. • Dr [redacted] lied to the Patient's Mother about Child Protection's involvement and the need to re-present to the hospital.
Monday [redacted] 2021	4:45am	• Mother awakes and sees a text message from Dr [redacted] She attempts to call him back, and after no response she sends the following text: *Sorry for the early morning text! Not sure how urgent and I'm up! Happy to bring [redacted] in. He will be up in an hour. We had been told by DR. [redacted] at ED to make a GP appt next wed/thursday for follow up scans. A discharge summary or care plan may have been useful.* • No text response from Dr [redacted] is received.	
	9:30am	• Parents of the Patient engage the Virtual ED service at Northern Health, from their home at [redacted], to further follow up on Dr [redacted] text and call. • Dr [redacted] attends and assesses the Patient. She checks his record for requests for further testing. No such request is found. Parents again query why an outpatients' appointment is not required or why a discharge summary was not provided. Dr [redacted] is unable to provide a satisfactory response. She does, however, reassure parents that a 'green stick' injury such as the one experienced by the Patient will heal within a week or so, that they are quite common, and the injury should not impact or affect the patient long term in any way. Patient is happy, settled and comfortable. Dr [redacted] does not see a need for further or repeat scans, nor are there any notes regarding a need for additional scans present on the Patient's file.	

	10:51am	• Dr [redacted] calls the Mother from a private number. Dy [redacted] requests that the Mother presents the Patient back to ED at Northern Health for further scans and testing. • Mother informs Dr [redacted] that the Patient has already been assessed by Virtual Ed and no further tests were scheduled. • Dr [redacted] informs mother that he suspects 'abuse' and requests the Mother present back to ED stating that she suspects abuse and requesting a review. • Mother asks if criteria for mandatory reporting is subjective or at the discretion of the doctor. Dr [redacted] responds that yes, indeed it is, but that he did so based on 'severity' of the injury and that he was unsatisfied with Father's description of mechanisms of injury. • Dr [redacted] states that "the case just ticked too many boxes". Mother asks which boxes exactly. Dr [redacted] responds that Aboriginality has nothing to do with the case. • Mother is distraught and once again, states that the injury was the result of an accident, poor timing and again, describes the mechanism of injury and the Father's response post injury, to which Dr [redacted] dismissively laughed. • She agrees to attend Northern Health with the Patient but will not state that she is doing so due to a suspicion of child abuse neglect or violence towards the child. • Despite compliance by the mother, Dr [redacted] then misleads the Mother, when he states that "You don't have a choice anyway. Show up or the police and Child Protection will come to your house". Dr [redacted] also goes on to state that regardless of the result of further testing, he is convinced of violence towards the patient. Dr [redacted] warns mother to "not be so stroppy" with hospital staff as it suggests guilt and an unwillingness to comply. • Mother is crying, fearful and shamed into silence, unable to then speak honestly and openly with Dr [redacted] Thanks him for his time and ends the phone call.	

	Approx 11:30am	• Mother presents patient to Northern Health after first calling Victorian Aboriginal Child Care Agency (VACCA) and Child Protection for advice and support. She finds that a case had not been raised with VACCA. Child Protection also confirm that no such case was lodged. However, after several conversations with ALO [redacted] Mother presents to Northern Health ED, fearing the forced removal of her child (the Patient). • At this point, the Mother is unaware that Dr [redacted] had misled her into presenting back to Northern Health. • The parents had still not received a discharge summary, as promised. • Mother felt misled and manipulated into giving consent to the unnecessary invasive and distressing medical testing, examinations and monitoring to be performed on the Patient. Mother is one of three people required to pin down the patient in order to undertake the full body Xray survey. • At no point did any member of staff correct this misinformation, nor question the requirement for further intervention. • During this hospital visit, the Patient underwent unnecessary invasive and distressing medical testing, examination and monitoring. The tests included a full body X-Ray and blood tests. Patient and Mother also had medical staff observing them. • Mother felt misled and manipulated into giving consent to the unnecessary invasive and distressing medical testing, examinations and monitoring that were performed on the Patient. These were performed not for medical reasons, but for a Child Protection claim that had already been rejected by Child Protection and VACCA. As noted above, Dr [redacted] had lied to the parents about the existence of a Child Protection report. • Treating doctor (Dr. [redacted] informs mother that the wrong cast was placed on the patient's injured arm. Mechanism of injury were again explained by the mother, however upon	• Given that there was no case with VACCA or Child Protection, the family were not offered support and advocacy services usually provided by these agencies during this process. • At no point did ANY member of staff at Northern Heath, Epping inform mother that no child protection case had indeed been raised. • An Aboriginal Liaison Officer was not physically present • A social worker claimed to have met with the mother, however this never occurred. • [redacted] was subjected to unnecessary invasive and distressing medical tests and approx..7 hours of monitoring at Northern Health, Epping. • Discharge summary provided, however upon review by the mother, mechanisms recorded are found to be consistent with mother's retelling of events to treating doctor. Required amending before leaving.

		discharge mother found the doctor has mis-recorded mechanisms by treating doctor. Mother insists the patient's record be amended to record mechanisms of injury as described by parents.	
Several weeks later		• The parents were able to talk directly to the case worker at VACCA who had consulted Dr [redacted] on the night of the [redacted]. It was only then explained that no Child Protection case had ever been formally raised.	

Northern Health

Our Reference: [redacted]
Direct Line: [redacted]

[redacted] 2022

[redacted] and [redacted]
By email: [redacted] and [redacted]

Dear Mr [redacted] and Ms [redacted]

I am writing in response to the concerns you raised with Northern Health in your email dated [redacted] 2022 (Email) regarding the management of your son, [redacted] ([redacted]) at Northern Health between [redacted] 2021 and [redacted] 2021. From the outset, I apologise on behalf of Northern Health for any pain or suffering [redacted] recent admission to Northern Health has caused to [redacted] and his family.

We thank you for taking the time to provide your detailed feedback to Northern Health. Your feedback has allowed us to identify ways to improve our care of any family where non-accidental injury is considered. Furthermore, you have highlighted for us the important impact that our necessary actions in these circumstances may have on an Aboriginal family. For ease we have broken down our response into sub-headings which canvass what we believe to be the key themes in your email and [redacted] journey through Northern Health.

Northern Health's review into [redacted] care

Northern Health completed a review into the circumstances around [redacted] presentation and management. Due the nature of your feedback, Northern Health has incorporated the techniques involved in a Root Cause Analysis (RCA) review to ensure all findings are upheld and implemented to the utmost standard. For the purposes of our response below, we refer to our review as an RCA and all findings are incorporated into this letter.

A RCA is a detailed and thorough investigation to identify process and system issues. It aims to identify what happened, why certain events occurred and what can be done to reduce the risk of it happening again. A RCA does not focus on individual clinicians and their actions, and is not meant to attribute blame to individuals. More information on the investigation process can be found at the following website - https://www.health.vic.gov.au/quality-safety-service/clinical-incident-investigations-root-cause-analysis.

The RCA consisted of a panel of internal and external experts in paediatric medicine, Northern Health's Paediatric Outpatient Department and a representative from the Victorian Forensic Paediatric Medical Service. There was also an external Aboriginal representative from another health service who provided independent guidance, specifically on Aboriginal cultural considerations. The RCA review was completed on [redacted] 2022.

The findings identified below, whilst looking at process and system issues, were made with the view of what the panel believed would have been the most appropriate course of action taken to treat [redacted] to ensure optimum care, taking into account cultural sensitivity and to reduce the significant distress you experienced.

Statutory mandatory reporting

Mandatory reporting where there is a reasonable belief of child abuse or neglect is a legal requirement for professional groups (such as hospital staff). Staff attending to [redacted] on [redacted] 2021 formed the reasonable belief that the injury he sustained was sufficient and unique enough to warrant further investigation. Child Protection were contacted for advice, and Northern Health was advised that Child Protection would not open an investigation unless the clinician was sure this injury had occurred as the result of a non-accidental trauma. The review concluded that this advice was not in keeping with standard practice. However, Child Protection did suggest that the Victorian Forensic Paediatric Medical Service (VFPMS) be contacted for further advice. The VFPMS is a 24-hour service that provides advice and secondary consultations for Victorian health professionals in relation to suspected child abuse, including physical injuries. As the call was conducted after hours, VFPMS had notified the clinician attending to [redacted] that the VFPMS doctor was busy and the clinician requested a call back, which was not received. As VFPMS could not be contacted on the night of presentation, the clinician wrote in [redacted] medical record that he would try to contact them again the following day.

Clinical matters

Discharge from the Emergency Department on [redacted] and GP follow up
After not being able to contact VFPMS, [redacted] was treated for his injuries, including the application of a cast to his injured arm. He was then discharged from the Emergency Department (ED), with GP follow up in two weeks. It is understood that this decision was made based on timely follow up with a GP in the community and the relative low risk of discharging [redacted] home. The review determined that this was appropriate, however, a more fulsome management plan would have consisted of admitting [redacted] to the Paediatric ward overnight so that further investigations could continue and staff could be assured of [redacted] safety. Furthermore, an inpatient admission is likely to have led to clearer and more consistent communication, together with more coordinated support for your family, including the engagement of Social Work.

The review determined that instead of referring [redacted] to his GP for follow up, a more considered approach would have been that [redacted] return to Northern Health's fracture clinic for follow up, which ultimately occurred on [redacted] 2021. We understand that [redacted] was not provided with a discharge summary upon departure of the ED and we apologise for this. This is not our usual practice and it is an expectation that all discharged patients receive this document.

Internal handover
The review identified that there was no clear handover between Northern Health clinicians. The doctor who saw [redacted] in the ED attempted to follow him up, and manage ongoing care without handing over to anyone else. This likely led to a delay in making contact with the VFPMS and actioning their advice. Furthermore, there is a lack of clinical documentation within [redacted] medical record, which led to conflicting advice in ongoing consultations with Northern Health.

Follow up for further treatment
We understand that you were concerned when you saw the missed telephone calls from our staff, particularly because of the times these calls were made. On this occasion, the attending doctor had made contact with VFPMS who strongly recommended follow up testing. It was considered urgent that [redacted] return to the hospital as soon as possible. The doctor attempted to call twice, before sending the text message that we now understand caused you distress. We apologise that this communication occurred in this way. The communication was not intended to mislead, manipulate or cause distress. The phone call was made on the advice of experts at VFPMS, who considered that follow up should take place as soon as possible. The attending doctor was advised that [redacted] should

return to Northern Health for immediate review without thinking of the impact of the language chosen.

A learning from the review is that we will endeavour to provide direct telephone contact details, including the treating clinician's name and area, for all patients when telephone contact cannot be made and a text message is required to be left.

Ongoing treatment and management at Northern Health

On [redacted] 2021, investigations to exclude a non-accidental injury were conducted. These included a Paediatric skeletal survey and blood tests. The x-ray confirmed that no other traumatic injury was evident, in particular there were no signs of injuries which are often associated with non-accidental injury. Blood tests were within normal limits and updates by the attending ED Paediatrician to Child Protection and VFPMS were provided. The cast was replaced with an above elbow cast. The back slab applied to [redacted] was initially suboptimal but unlikely to have caused any delay to healing or harm to [redacted] The risk of the back slab is that further displacement of the fracture could occur. The skeletal survey taken on [redacted] 2021 showed that the bones were in satisfactory alignment and the arm was placed in the appropriate cast on that day.

Whilst Child Protection did not open a case, they did investigate the initial report made on [redacted] 2021. On [redacted] 2021 and [redacted] 2021, Child Protection contacted Northern Health's Social Work department to seek further information. Social Work agreed to continue to liaise with Child Protection and to inform them when [redacted] and his parents presented to ED again.

Social Work received a phone call from the Aboriginal Liaison Officer (ALO) requesting Social Work support [redacted] during [redacted] return to the ED for further testing. At this time, which was during the COVID-19 pandemic, the ED was declared a red zone, and Social Work were unable to visit. However, they liaised with clinicians in the Paediatric Area and offered their support should [redacted] be admitted.

It was Social Work's understanding that Child Protection were still investigating the initial report and they rang Child Protection on [redacted] 2021 to check they had received information regarding [redacted] presentation to ED on [redacted] 2021. During this phone call, the Child Protection worker informed Social Work that she was uncertain if the report would progress to the Investigations Team. She stated it was likely to be closed at intake, but that this has not been confirmed.

Aboriginal Liaison Officer support

Unfortunately, ALOs are only available at Northern Health during weekday working hours. Staff in the ED can refer a patient seen over the weekend or after hours via phone, paper referral or email. These referrals are followed up the next business day.

Northern Health has made attempts to increase ALO support in the ED, and these efforts continue. We will be recruiting for two new additional roles in our ED shortly, which will help us achieve greater coverage over weekends and afterhours. More broadly, we have an Aboriginal and Torres Strait Islander employment strategy which outlines our three-year plan to increase the attraction and retention of Aboriginal and Torres Strait Islander staff across the health service. This work is aligned with our Reconciliation Action Plan and our goal of providing a culturally safe service. We are also currently assessing our performance against the new Child Safety Standards from the Commission for Children and Young People which has a focus on cultural safety and respecting and valuing the diverse and unique identities and experiences of Aboriginal children.

Additional concerns

Emergency Department flow

The Northern Hospital ED is the busiest ED in Victoria. As a result of high levels of Paediatric presentations at Northern Health, it is common practice for Paediatric doctors to complete a brief rapid review of children in the waiting room and direct them straight to Radiology while awaiting a more extensive assessment. This practice means that more information will be available when the formal review occurs, ultimately leading to a speedier discharge. At the time of [redacted] presentation on [redacted] 2021, [redacted] was a close COVID contact. At this time, Northern Health was seeing children with COVID or a COVID exposure in the suspected COVID (SCOVID) waiting room area. In this space there were two bed assessment areas and two chair assessment areas which were at capacity with patients. We acknowledge that this could have been managed in a more appropriate manner, given the nature of what was discussed with [redacted] during this presentation.

Radiology exposure and VFPMS guidelines

With regards to your comments that [redacted] was exposed to unnecessary full body x-ray screening and blood tests, and your further comment regarding the failure to perform blood tests due to his [redacted], the review found that the investigations conducted were in accordance with guidelines published by the VFPMS. Although, as mentioned above, it would have been preferable to perform these investigations as part of the initial presentation, the investigations which were ultimately performed were deemed clinically appropriate by the review panel.

The VFPMS guidelines note that all fractures in non-ambulatory children are deemed concerning for abuse, and that in infants, fractures are more commonly attributed to abuse than to accidents. These guidelines recommend a skeletal survey as necessary in all children 0-11 months with the type of fracture that [redacted] sustained. [redacted] would not necessarily warrant blood tests where there is no concern of abuse. However, in order to clarify the absence of an underlying medical disorder, blood tests were indicated in this instance.

With respect to your concerns about Radiology and the provision of protective equipment, we have met with the Acting Manager of our contracted Radiology provider, Lumus Imaging. Staff who attended to [redacted] recall giving [redacted] a protective apron to wear during the procedure and he was behind the screen for most of the x-ray. The provision of protective lead equipment is routine practice within the department for any family or staff members assisting with procedures.

Your concerns

Your Email highlights various matters which you would like Northern Health to action by way of redress. Referring to matters (a) and (b), as previously stated, the purpose of our review was not to look at individual actions, conduct a retrospective analysis of clinicians or attempt to attribute individual blame. If you would like investigations to be conducted into the actions of individual staff members, please contact the Australian Health Practitioner Regulation Agency (AHPRA). In reference to (d), Northern Health is a model litigant. As a model litigant under the Victorian Model Litigant Guidelines, it is inappropriate for Northern Health to engage in resolving a claim for compensation where the claimant is unrepresented and has not had the benefit of independent legal advice. If this is something you wish to pursue, you should seek legal advice or contact the Health Complaints Commissioner. I believe the balance of the matters in part 7 of your Email are addressed by this response.

Northern Health deeply regret the gaps in our care and processes that have been identified through your feedback and our review of [redacted] care. Gaps in our communication, documentation, handover and a lack of timely follow up contributed to the very poor experience you have shared with

us. We believe that contact with Child Protection, VFPMS and the further investigations and blood tests were necessary, however, the decision to discharge [redacted] home after his initial presentation was not the best course of action. In addition, cultural sensitivities were not taken into account during [redacted] presentation. These actions meant that you did not receive adequate information and supports to help you through this very difficult process.

We were saddened to read of the experience you had and the devastating impact it has had on your family. If you would like to discuss this response further, we would be happy to meet with you. Northern Health has learnt from your experience and, when the time is right for you, we would ask your permission to use your story as part of that learning process and to engage in further dialogue with you in relation to using your journey to improve our health service for all of our communities.

Yours sincerely

[redacted]

[redacted]

The Patient Experience Office would be happy to assist you with any further concerns you may have. They can be contacted on 8405 2457or via email at feedback@nh.org.au. Please contact them or our Aboriginal Support Unit is you would like for a meeting to be arranged. Alternatively, you are welcome to contact the Health Complaints Commissioner (HCC) on 1300 582 113. More information about the HCC service is on their website: https://hcc.vic.gov.au.

cc: Safer Care Victoria (via email only)

Response to Root Cause Analysis conducted by Northern Health concluded [redacted] 2022 in regards the care of [redacted] 2021

1. A Root Cause Analysis does not look to identify incidences of individual accountability, even when findings within the RCA suggest it necessary. Here, there is evidence to suggest further inquiry into individual accountability is warranted. Therefore a RCA, does not provide a suitable framework from which to sufficiently investigate this case, nor other cases of suspected abuses of power, malpractice and the deliberate circumnavigation of policy and protocols set in place to safeguard against these.

Clinical Matters

2. Discharge from the Emergency Department on [redacted] and GP follow up (p.2)

"After not being able to contact VFPMS, [redacted] was treated for his injuries, including the application of a cast to his injured arm. He was then discharged from the Emergency Department (ED), with GP follow up in two weeks. It is understood that this decision was made based on timely follow up with a GP in the community and the relative low risk of discharging [redacted] home. The review determined that this was appropriate, however, a more fulsome management plan would have consisted of admitting [redacted] to the Paediatric ward overnight so that further investigations could continue, and staff could be assured of [redacted] safety. Furthermore, an inpatient admission is likely to have led to clearer and more consistent communication, together with more coordinated support for your family, including the engagement of Social Work.

The review determined that instead of referring [redacted] to his GP for follow up, a more considered approach would ***have been that [redacted] return to Northern Health's fracture clinic for follow up, which ultimately occurred on [redacted] 2021.*** *We understand that [redacted] was not provided with a discharge summary upon departure of the ED and we apologise for this. This is not our usual practice and it is an expectation that all discharged patients receive this document."*

i.) There were no grounds for mandatory reporting. Both VACCA and Child Protection determined that there were no grounds to file a child protection report. The injury is consistent with mechanisms of the fall (FOOSH), greenstick fractures in children under the age of 9 months do not trigger mandatory reporting. There was no evidence whatsoever that this was anything but an accidental injury. There was no prior history of abuse, neglect, or mistreatment. There were no behavioural warnings witnessed. Dr. [redacted] notes state [redacted] was "observed to be close and affectionate with dad". No evidence of drug or alcohol use. There were no grounds to suspect any risk of harm. Therefore, there was no grounds to admit [redacted] based on suspicion of risk of harm.

ii.) [redacted] was referred to the fracture clinic at the insistence of his mother. This referral was made on the [redacted], but he did not attend the clinic on this day.

iii.) In not providing [redacted] with a discharge summary, he was not able to correct the mechanisms of injury misreported by Dr.[redacted] Nor address the other errors made by Dr.[redacted] regarding family situation.

iv.) NOTE- not only was [redacted] denied a discharge summary, despite repeated requests, [redacted] (Mother) was told by hospital staff that it wasn't common practice to provide patients with a discharge summary, when she rang in the early morning of the [redacted], requesting information on follow up care. [redacted] was informed that a discharge summary may be provided to her GP, if she insisted. Further clarification is required into correct procedure and policy.

3. Internal Handover (p.2)

"The review identified that there was no clear handover between Northern Health clinicians. The doctor who saw [redacted] *in the ED attempted to follow him up and manage ongoing care without handing over to anyone else. This likely led to a delay in making contact with the VFPMS and actioning their advice. Furthermore, there is a lack of clinical documentation within* [redacted] *medical record, which led to conflicting advice in ongoing consultations with Northern Health".*

i.) As an RCA avoids investigation of an individual's actions, Northern Health did not investigate why there was no clear handover, nor why there was a lack of clinical documentation. It is our suspicion that Dr. [redacted] acted outside of policy and protocol and therefore intentionally neglected to adequately document his actions.

4. Follow up for further treatment (p. 2-3)

"We understand that you were concerned when you saw the missed telephone calls from our staff, particularly because of the times these calls were made. On this occasion, the attending doctor had made contact with VFPMS who strongly recommended follow up testing. It was considered urgent that [redacted] *return to the hospital as soon as possible. The doctor attempted to call twice, before sending the text message that we now understand caused you distress. We apologise that this communication occurred in this way. The communication was not intended to mislead, manipulate or cause distress. The phone call was made on the advice of experts at VFPMS, who considered that follow up should take place as soon as possible. The attending doctor was advised that* [redacted] *should return to Northern Health for immediate review without thinking of the impact of the language chosen.*

A learning from the review is that we will endeavour to provide direct telephone contact details, including the treating clinician's name and area, for all patients when telephone contact cannot be made, and a text message is required to be left."

i.) Please provide detailed records of conversations between Dr. [redacted] and VFMPS. If a recording is available, we request access.

ii.) Dr [redacted] had placed a call at around 10 pm on Sunday [redacted]. A text message and contact details was left. This call was from a private number and missed by the mother. Mother returned the call at approximately 5am, and this was subsequently missed by Dr. [redacted] The parents did seek further advice at 9am Monday [redacted] but was informed that no further follow up was required (see Annexure A)

iii.) As an RCA does not aim to address individual action, there has been no proper investigation into the language used by the doctor, in a subsequent call, on [redacted], whereby threats were made of immediate removal constituting coercion. The mother was asked to present to NH and to claim to believe [redacted] was in immediate risk of harm, so as to trigger a Child Protection response. Additionally this RCA does not address the mention the obvious impact aboriginality had in informing Dr [redacted] actions, as outlined in Annexure A.

iv.) This response makes no mention the threats, coercion, name calling, condescension made to the family, nor does it mention Dr. [redacted] position where aboriginality presented as the sole indicator for risk of harm.

v.) This response does not suggest how families will be protected from such actions in the future

5. Ongoing treatment and management at Northern Health (p.3)

On [redacted] *2021, investigations to exclude a non-accidental injury were conducted. These included a Paediatric skeletal survey and blood tests. The x-ray confirmed that no other traumatic injury was evident, in particular there were no signs of injuries which are often associated with non-accidental injury. Blood tests were within normal limits and updates by the attending ED Paediatrician to Child Protection and VFPMS were provided. The cast was replaced with an above elbow cast. The back slab applied to* [redacted] *was initially suboptimal but unlikely to have caused any delay to healing or harm to* [redacted] *The risk of the back slab is that further displacement of the fracture could occur. The skeletal survey taken on* [redacted] *2021 showed that the bones were in satisfactory alignment and the arm was placed in the appropriate cast on that day.*

Whilst Child Protection did not open a case, they did investigate the initial report made on [redacted] *2021.* ***On*** [redacted] ***2021 and*** [redacted] ***2021, Child Protection contacted Northern Health's Social Work department to seek further information. Social Work agreed to continue to liaise with Child Protection and to inform them when*** [redacted] ***and his parents presented to ED again.***

Social Work received a phone call from the Aboriginal Liaison Officer (ALO) requesting Social Work support [redacted] *during* [redacted] *return to the ED for further testing. At this time, which was during the COVID-19 pandemic, the ED was declared a red zone, and Social Work were unable to visit. However, they liaised with clinicians in the Paediatric Area and offered their support should* [redacted] *be admitted.*

It was Social Work's understanding that Child Protection were still investigating the initial report and they rang Child Protection on [redacted] 2021 to check they had received information regarding [redacted] presentation to ED on [redacted] 2021. During this phone call, the Child Protection worker informed Social Work that she was uncertain if the report would progress to the Investigations Team. She stated it was likely to be closed at intake, but that this has not been confirmed.

i.) Child Protection contacted Northern Health Social Work, after receiving a call from the mother from the NH car park in extreme distress, after being coerced into presenting back to NH and asked to lie by a doctor. Child Protection reassured the mother that so such case existed. Child protection placed the call to Northern Heath to question why the family was being asked to present back, if no case had been raised and there was no further action required.

6. Aboriginal Liaison Officers (p. 3)

"Unfortunately, ALOs are only available at Northern Health during weekday working hours. Staff in the ED can refer a patient seen over the weekend or after hours via phone, paper referral or email. These referrals are followed up the next business day.

Northern Health has made attempts to increase ALO support in the ED, and these efforts continue. greater coverage over weekends and afterhours. More broadly, we have an Aboriginal and Torres Strait Islander employment strategy which outlines our three-year plan to increase the attraction and retention of Aboriginal and Torres Strait Islander staff across the health service. This work is aligned with our Reconciliation Action Plan and our goal of providing a culturally safe service. We are also currently assessing our performance against the new Child Safety Standards from the Commission for Children and Young People which has a focus on cultural safety and respecting and valuing the diverse and unique identities and experiences of Aboriginal children."

i.) In our experience, Aboriginal Liaison Officers are employed by the hospital and as such, are unable to provide adequate and meaningful advice and support to families when complaints are necessary. A review into the constraints placed on ALOs as a consequence of their employment by the institution is necessary. ALO should have a sole obligation to ensure the welfare of ATSI families. This is not currently the case.

Additional Concerns

7. Emergency Department flow (p.4)

"The Northern Hospital ED is the busiest ED in Victoria. As a result of high levels of Paediatric presentations at Northern Health, it is common practice for Paediatric doctors to complete a brief rapid review of children in the waiting room and direct them straight to Radiology while awaiting a more extensive assessment. This practice means that more information will be available when the formal review occurs, ultimately leading to a speedier discharge. At the time of [redacted] presentation on [redacted] 2021, [redacted] **was a close COVID contact.** *At this time, Northern Health was seeing children with COVID or a COVID exposure in the suspected COVID (SCOVID) waiting room area. In this space there were two bed assessment areas and two chair assessment areas which were at capacity with patients. We acknowledge that this could have been managed in a more appropriate manner, given the nature of what was discussed with [redacted] during this presentation."*

i.) [redacted] WAS NOT a close COVID contact, nor was he declared a close contact by his family. He had been tested on the [redacted] (Negative), at NH on the [redacted] (Negative) and again on the [redacted] (Negative), as precautionary measures due to high incidences of cold and flu symptoms within the family.

8. Radiology exposure and VFPMS guidelines

"With regards to your comments that [redacted] was exposed to unnecessary full body x-ray screening and blood tests, and your further comment regarding the failure to perform blood tests due to [redacted], the review found that the investigations conducted were in accordance with guidelines published by the VFPMS. Although, as mentioned above, it would have been preferable to perform these investigations as part of the initial presentation, the investigations which were ultimately performed were deemed clinically appropriate by the review panel.

***The VFPMS guidelines note that all fractures in non-ambulatory children are deemed concerning for abuse, and that in infants, fractures are more commonly attributed to abuse than to accidents. These guidelines recommend a skeletal survey as necessary in all children 0-11 months with the type** of fracture that [redacted] sustained. [redacted] would not necessarily warrant blood tests where there is no concern of abuse. However, in order to clarify the absence of an underlying medical disorder, blood tests were indicated in this instance.*

With respect to your concerns about Radiology and the provision of protective equipment, we have met with the Acting Manager of our contracted Radiology provider, Lumus Imaging. ***Staff who attended to [redacted] recall giving [redacted] a protective apron to wear during the procedure and he was behind the screen for most of the x-ray. The provision of protective lead equipment is routine practice within the department for any family or staff members assisting with procedures."***

i.) [redacted] was [redacted] at the time of the accident, therefore guidelines pertaining to children aged between 0-11 months are non-applicable in this case. [redacted] was at the time sufficiently 'ambulant' to accidently cause the injury, as described by the father and mother.

ii.) VFPMS reporting guidelines state: "… if one of the following fractures is detected as the only injury then additional radiological investigation is not necessary. Distal radius/ulna fracture in a toddler aged > 9 months AND a history of a fall". The injury [redacted] sustained, and the mechanisms of the injury do not warrant further investigation according to DHHS, VACCA or VFPMS and are indeed EXEMPT according to VFPMS guidelines. Again, there were not mandatory nor historic or observed grounds for presumption of risk of harm, nor evidence of previous harm, mistreatment, neglect, abuse of any kind. We maintain the only risk of harm, as articulated by Dr [redacted] was that perceived based on his aboriginality ("ticked too many boxes").

iii.) According to VFPMS green stick fractures to the ulnar and radius are most commonly caused by falling on an outstretched hand (FOOSH), as described by both parents in [redacted] case, but then mis-recorded by Dr. [redacted] and later corrected by Dr. [redacted] on the [redacted].

iv.) Contrary to "staff recollections" NO lead protective apron was provided to [redacted] despite his request. He remembers clearly being told one was not necessary. There was NO protective screen. The xray was conducted outside of radiology department, close to the exit of the main waiting room, near front of emergency. [redacted] was sat in a chair with [redacted] who was wearing protective clothing who was on [redacted] lap. A portable x ray machine was used. There was no screen.

9. Your concerns (p.4-5)

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i.) There were no grounds for the additional x rays, blood tests, monitoring. There was no child protection case, nor evidence to suggest any risk of harm at all.

ii.) VACCA were not contacted after the initial phone call placed on the [redacted]. A case was never raised and therefore, the safeguards and protective measures set in policy, protocol and law were not made available to the family.

iii.) It is clear, that in this case, a Root Cause Analysis was not the most appropriate method of review, given the family sited evidence of racism, intimidation, and coercion. A full enquiry was requested but not conducted, so as to avoid addressing these concerns of racism and the actions of Dr [redacted] There is clear evidence that Dr [redacted] pursued a child protection order without merit or grounds and did so outside of policy, protocol, and law. There were no grounds for mandatory reporting and so, Dr [redacted] set about looking for alternative means to look for grounds to report. His actions have long lasting consequences for our family and highlight the ever-present threat of harm First Nations families continue to manage.

In electing to conduct a Root Cause Analysis instead of a full inquiry, Northern Health have knowingly mismanaged and manipulated the review process so as to avoid addressing systemic issues of racism and abuse of power within Health.

Regards,
[redacted] and [redacted] on behalf of [redacted]