CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of BR
Hearing dates:	12 October 2023
Date of findings:	20 October 2025
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW –12-month-old infant, unascertained cause of death- medical event at home leading to cardiac arrest-treatment in Manning Base and John Hunter Hospitals-death 9 days after vaccination-genetic testing
File number:	2020/222706
Representation:	Sergeant Amanda Chytra Coronial Advocate assisting the Coroner Ms S Freyen for Hunter New England Local Health District

Findings:

I make the following findings in relation to the death of BR, pursuant to s 81 of the *Coroners Act 2009* (NSW):

Identity:

The person who died is BR

Date of death:

BR died on 29 July 2020.

Place of death:

BR died at John Hunter Hospital, Newcastle

Cause of death:

The cause of BR's death is unascertained

Manner of death:

BR died of natural causes

JUDGEMENT

Introduction

1 BR was born on 18 July 2019 at John Hunter Hospital. In the early hours of the morning of the 28 July 2020 BR suffered a cardiac arrest whilst at home. BR passed away at 3pm on 29 July 2020 at John Hunter Hospital in Newcastle.

Inquest

2 An inquest was held on October 12, 2023. BR's mother, father and grandmother all attended the inquest and retained a close interest throughout both the investigation and inquest phases of the coronial process.

3 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death.

4 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the *Coroners Act 2009* (NSW) (the Act); namely:

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of the person's death.

5 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learnt from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

Coronial Investigation

6 Prior to holding the inquest, a detailed coronial investigation was undertaken by Detective Senior Constable (DSC) Belinda Johnson. DSC Johnson compiled a brief of evidence which included statements from BR's mother, medical practitioners and other police officers. The brief also included a report by forensic pathologist, Dr Du Toit-Prinsloo as to doctor's findings upon post-mortem examination. The court also received extensive medical records, and (initially) an expert report from Dr Simon Craig.

7 All the documents including witness statements and expert reports obtained during the coronial investigation formed part of the two-volume brief of evidence that was tendered at the commencement of the inquest.

Witnesses

8 The following witnesses gave oral evidence in the inquest. Detective Senior Constable Johnson, Professor Nicholas Wood and Dr Du Toit-Prinsloo.

Issues considered in the Inquest

9 An inquest was required to be held by operation of s 27(1)(c) and 27(1)(d) of the Coroners Act, as the cause of BR's death had not been sufficiently disclosed. BR's family had been and remain concerned about the care and treatment provided to BR at Manning Base Hospital. In regard to this issue, two expert reports from Professor Simon Craig are now in evidence (one having been provided after the hearing).

10 The primary focus at inquest was a consideration of the cause of BR's death. Specifically, the focus was to hear oral evidence regarding the cause of BR's cardiac arrest.

Medical History

11 BR did not have any known significant medical conditions. He had attended the Forster Tuncurry Medical Centre a number of times for minor illnesses and was up to date with his vaccinations.

12 BR received his 6-month immunisations on 30 August 2019 which comprised of Infanrix Hexa, Prevenar 13 and Rotarix. There was no reaction observed immediately after the vaccinations but on 2 September 2019 BR was taken to the Glendale Medical Centre as his mother was concerned that he was developing an adverse reaction to his immunisations. BR was reportedly dry retching small amounts of white mucous and was upset.

13 On 8 September 2019, BR's mum took BR to John Hunter Hospital concerned about BR's flushed cheeks, congested nose, cough and temperature. He was discharged with a possible respiratory tract infection.

14 BR received his 12-month vaccinations on 20 July 2020 when he was given Priorix, for measles, mumps and rubella, known as the MMR vaccine, Nimenrix, a vaccine against meningococcal and Prevnar 13, a vaccine against pneumococcal. There was no reaction observed immediately after these vaccines were administered.

Events leading up to BR's death

15 On Sunday 26 July 2020, BR was happy and well throughout the day.

16 On the morning of 27 July 2020, BR woke up around 5.30am and drank 160mls of baby formula. He went back to sleep until 7.15am and drank the remainder of the formula when he awoke. BR settled somewhat over the course of the morning, however, he didn't eat or drink as much as usual during the rest of the day and BR's mother gave him a 5ml dose of Neurofen.

17 During the afternoon of 27 July BR was still unsettled. BR's mother drove with BR from Lambton to her home at Forster, about a two-hour car trip. BR's mother and BR arrived home to Forster around 4.45pm and BR slept the entire car ride. When BR's mother got BR out of his car seat, she felt that he was extremely hot to touch. She checked his temperature, and it was 38.5 degrees. She removed his shirt and jeans to cool him down. BR's mother saw that BR had a red rash on his arms which was also spreading to his cheeks and she decided to take BR to Manning Base Hospital.

18 BR's mother and BR arrived at the Emergency Department at Manning Base Hospital in Taree about 6.10pm on 27 July 2020. At 6.20pm BR was assessed by a Triage Nurse and he was triaged as a category 4 patient. This is a semi-urgent triage category with the patient to be seen within one hour. BR's temperature reading was 37.9 degrees and because of his rash, BR and BR's mother were taken to an isolation room as a precaution as this was during the Covid-19 pandemic.

19 BR and his mother waited for a period of almost four hours in the isolation room. In this time BR's mother recalls that a member of the nursing staff provided hot water for BR's bottle on request and she states that the nurse also brought a bubble wand in to help distract BR.

20 BR and BR's mother waited in the isolation room until they were seen by a doctor at 9.58pm. The Doctor was the Senior Medical Officer in charge of the Emergency Department at Manning Base Hospital on 27 July 2020. The Doctor observed that BR looked well and was happy and interactive and the rash that he had initially presented

with was no longer visible. BR's heart rate and blood pressure were normal. His chest was clear and his abdomen was soft and non-tender. Doctor's impression was that the rash and fever were consistent with a viral illness and that no treatment was required. He requested a repeat set of observations be done.

21 At 10pm a Registered Nurse undertook the requested repeat observations and recorded them on the triage sheet as a temperature of 37.4 degrees, oxygen saturation of 98% on room air, a heart rate of 114, respiration rate of 33 and a Glasgow Coma Scale of 15 out of 15. All the observations taken were within the normal range. BR was discharged at 10.15pm. BR's mother was not provided with any discharge paperwork or fact sheets.

Arrival Home from Manning Base Hospital

22 BR's mother and BR arrived home around 11.15pm. BR didn't wake up when his mother got him out of the car, and she put him straight into his cot where she took his temperature which was 38.4 degrees. Shortly before 2am on 28 July 2020 BR woke up crying. BR's mother got up and went to the kitchen to make a bottle before returning to the bedroom. She placed the bottle on BR's drawers and turned BR over from his stomach to check his temperature which returned a reading of 38.8 degrees. This prompted BR's mother to call Manning Base Hospital for advice. Phone records confirm that BR's mother made this call at 1.57am and the call lasted approximately 4 minutes and 45 seconds. BR's mother recalls that she was told that there were no notes in the system for BR's earlier attendance and that she was unlikely to be seen until the morning. BR's mother states that she was not told to bring BR back into hospital. The hospital has been unable to determine which member of staff spoke with BR's mother.

23 BR's mother moved BR around so that he would wake up and she could give him his bottle as he would generally sleep longer after a feed. He drank 180ml of the 200ml bottle and went back to sleep. BR was stirring so BR's mother turned the TV off in case it was disturbing him. She lay back on the bed and was resting for approximately one minute before she heard BR scream. She thought he may have gotten his arm caught in the cot but when she turned the light on BR was lying on his stomach in his cot. BR's mother picked BR up but he wasn't responding, his eyes had rolled to the back of his head and his back and head were arched back as she held him. BR's mother ran into BR's father with BR in her arms and yelled, "BR isn't responding, I don't know what's wrong with him." BR's father took BR outside to try and cool him down whilst BR's mother called emergency services and commenced cardiopulmonary resuscitation (CPR). Call records show that BR's mother called 000 at 2.07am.

Emergency Services Response

24 Paramedics were dispatched and arrived and took over CPR. Resuscitation efforts continued as BR was transported to Manning Base Hospital. Paramedics administered adrenaline to BR and at 3am a cardiac output with a strong pulse was achieved.

25 BR arrived at Manning Base Hospital at 3.11am where he was intubated. During resuscitation, BR was vomiting a large amount of milk and suction commenced as he was actively aspirating.

26 Extensive efforts were made to resuscitate BR, but he had no circulation, and his heart was not beating without assistance. BR's pupils were fixed and dilated.

27 Arrangements were made to airlift BR to the John Hunter Hospital Paediatric Intensive Care Unit and BR arrived there around 8.40am.

28 BR was critically ill with what appeared to be severe brain injury due to lack of blood flow to his brain during the cardiac arrest. He had reduced cardiac function and injury to his liver and kidney which were also due to the lack of blood flow during the cardiac arrest. A CT brain scan showed severe brain swelling and an echocardiogram showed an abnormal appearance of the left ventricle with asymmetric myocardial thickening.

29 BR's ventilator was switched off at 4.50pm on 29 July 2020.

The care provided at Manning Base Hospital and John Hunter Hospital

30 An independent expert review of the care and treatment provided to BR at the Manning Base Hospital and John Hunter Hospital was sought from Professor Simon Craig, a paediatric emergency physician. The professor's shortform qualifications are MBBS, Honours, FACEM, MHPE, MPH. He is a paediatric emergency physician and adjunct clinical professor, Monash Medical Centre and Monash University. His studies and practice are interstate, removed from the New South Wales health system.

31 Professor Craig concluded that although BR did have some signs of toxicity during his first attendance at Manning Base Hospital, these signs were relatively mild and some had resolved prior to his discharge. He was of the opinion that there were no further tests that were clinically indicated, apart from a Covid-19 test, and that the assessment that he was suffering from a viral illness was reasonable. Professor Craig was also of the view that based on BR's presentation, admission to hospital for further investigations was not warranted and the decision to discharge BR from Manning Base Hospital was reasonable. It is to be noted that a Covid-19 swab was taken at John Hunter Hospital on 28 July 2020 which returned a negative result.

32 Professor Craig also reviewed the care and treatment provided to BR at John Hunter Hospital. He concluded that BR received the best care possible after arriving in a critical condition after a prolonged cardiac arrest.

33 Professor Craig noted that when BR was discharged from Manning Base Hospital, there was no documentation of any discharge advice or "safety netting" which is the provision of advice on the anticipated course of the illness, signs and symptoms to look out for, or reasons to return to a hospital. The professor pointed out that the practice of providing verbal and written information to families regarding their child's care is well-established, and many handouts are available for this purpose, e.g., Kids Health Information available and accessible at the website www.RCH.org.au/kidsinfo/.

34 On 20 May 2021, the provision of discharge letters to patients of Manning Base Hospital was audited and it was found that of the ten patient files audited, in seven cases, the discharge letter was appropriately provided, and the remaining three were not required as the patient had been admitted to hospital. On 14 July 2022, an audit of the emergency department observation charts was conducted. This audit revealed that the completion of authorisation for discharge from ED had been completed in 66.7% of required cases by nursing staff and only 25% of required cases by medical staff. The hospital identified this as an area for improvement and planned for subsequent audits and follow up to take place.

35 In undertaking these audits and putting in place steps for improvement, the hospital recognised a clear need to improve compliance with the completion of the discharge authorisation sections of the observation chart.

36 As indicated, there was no record of the phone call that BR's mother made to Manning Base Hospital at 1.57am on 27 July 2020. It was found that prior to BR's death, the hospital did not have a procedure in place to assist staff to deal with calls to the emergency department seeking medical advice. In response to this, a script was developed and implemented on 3 May 2021. Staff have been directed to use the ED phone script in all future calls when people ask for health advice over the telephone.

37 On 19 November 2020, Manning Base Hospital implemented the Royal Children's Hospital febrile child guidelines as part of a statewide change that was part of the paediatric improvement collaborative. These replaced the NSW Health Children and Infants with Fever - Acute Management policy.

38 I consider the steps taken by Manning Base Hospital subsequent to BR's death to be appropriate systemic improvements.

<u>What was the cause of BR's Death</u>

39 A post-mortem examination was conducted by Dr Lorraine Du Toit-Prinsloo on 31 July 2020. Despite the significant number of investigations which were conducted, the cause of BR's death was unable to be ascertained. BR's family raised concerns about the proximity between BR receiving his routine 12-month vaccinations on 20 July 2020 and his death on 29 July following the cardiac arrest.

40 Professor Nicholas Wood gave oral evidence. The professor is a paediatrician at Westmead Children's Hospital. He also works at the National Centre for Immunisation Research and Surveillance. On 29 June 2022 Professor Wood sat as part of the vaccine safety expert panel which discussed BR's case. The panel was made up of 18 experts, including a paediatric intensivist, a paediatric specialist, the forensic pathologist, Dr Du Toit-Prinsloo, a paediatric pathologist, a cardiologist, a geneticist and a paediatrician. Professor Wood chaired the panel. Professor Wood indicated that the panel felt strongly that genetic testing would be useful to understand the cause of BR's cardiac arrest.

41 Professor Wood's evidence was that sudden death is so very unusual in children that genetic testing is quite routine as it may explain whether events such as BR's are epileptic in nature or cardiac in nature. The professor also explained that there was no test that could be undertaken to determine definitively whether there was an adverse reaction to the MMR vaccine. The professor indicated that there was some emerging information in relation to a gene that is usually found in the Polynesian population that may be linked to severe adverse events after the MMR vaccine. BR's grandmother has some Maori heritage. It is unclear whether the identified gene is found in the Maori population.

42 Professor Wood's evidence was that it is unclear whether the underlying cause of BR's cardiac arrest was an epileptic event or a cardiac event, or possibly both.

43 Dr Du Toit-Prinsloo also gave oral evidence in relation to a fibroelastosis identified during the post mortem examination. The doctor explained and clarified that the subendocardial fibroelastosis in the subvalvular apparatus of BR's heart referred to an area of five brushes which is like when you itch yourself and get a scab and the body heals, so there is a white patch under the valve that was seen in the left atrium. The doctor further indicated that she discussed the finding with Dr Ella Sugo.

44 Dr Sugo is a paediatric pathologist. Her short-term qualifications are MBBS, FRCPA (Forensic). Dr Sugo set out the following:

> *"In summary, the finding in this child's heart are felt to be incidental as no mechanism can be postulated by which this could have caused the clinical scenario described, including death. The heart findings probably reflect an old and transient insult which occurred some time in the past. Whatever its cause, the insult has not caused significant alteration to the structure of the heart. There are no features to suggest this insult is recent or ongoing."*

45 Returning, then, to Dr Prinsloo's evidence, the doctor also indicated that Picornavirus, which was detected, is one of the common cold viruses commonly found in young children and was not causative of BR's death.

46 Finally, the doctor confirmed that the post-mortem would not reveal anything itself as to whether BR had suffered an epileptic episode.

Material and events after the hearing was completed

47 After the hearing was completed, all parties were given an opportunity to respond to *exhibit 4*, which was an article headed "*Seizure: European Journal of Epilepsy*", which examined issues surrounding genetic causes of epilepsy syndromes. It had also been contemplated that genetic testing may take place.

48 A short time after the hearing was completed, BR's father requested that I hold off delivering my findings to enable time for the family to have genetic testing of BR's younger sibling. As at the date of these findings, I do not have any evidence that BR's younger sibling has undergone genetic testing.

49 On 11 July 2024 Professor Craig provided a supplementary report following a number of issues being raised in correspondence from BR's father. In the supplementary report, Professor Craig answered questions about the administration of ceftriaxone and acyclovir at Manning Base Hospital, the appropriateness of administering this antibiotic and antiviral, whether their administration would affect the analysis of blood cultures and the appropriateness of the dose and timing of the administration. Professor Craig's key responses were:

(1) "It is my opinion that the administration of ceftriaxone and acyclovir was clinically appropriate under the circumstances of BR's presentation.

(2) It is my opinion that under most circumstances it would be appropriate to administer antibiotics after taking necessary blood samples. However, if there are difficulties obtaining the blood samples and the child is critically ill and thought to require urgent treatment, then treatment with antibiotics would take priority and should not be delayed to allow multiple further attempts at blood samples.

(3) It is my opinion that ceftriaxone administration at 3.33am would have reduced the likelihood that a bacterial infection would be detected. It is my opinion that

administration of acyclovir would not have had any effect on the blood culture result.

(4) *It is my opinion that BR was given an appropriate type and dose of antibiotics and antivirals and at an appropriate time."*

50 The Professor then referred to specific concerns raised in an email from BR's father. The Professor said:

> *"It is my opinion that it is possible that BR had a serious bacterial infection causing his illness and that administration of antibiotics before blood cultures were taken may have 'masked' this. However, it is my opinion that the need for urgent treatment (trying to cover all bases, including possible sepsis) in a critically ill child outweighed any concerns about antibiotics interfering with a blood culture result. If it had been easy to obtain a blood sample and send it for culture, then this would have occurred in a timely manner. It appears that it was very difficult to obtain a sufficient blood sample and the clinical team treating BR were prioritising* <u>*treatment*</u> *(antibiotics) to give BR the best chance of survival."*

51 I note in that passage the Professor underlined the word "treatment" to emphasise the word. The professor continued:

> *"Acyclovir is an antiviral medication which treats specific types of viruses (herpes virus, varicella zoster virus). It would not have affected the blood culture results and would not have affected the test for any types of viruses. Based on the information available, it is very difficult to determine whether BR died from a bacterial infection or another cause. However, it was reasonable to treat him with antibiotics (in order to treat a possible bacterial infection) and it was also very difficult to obtain intravenous access or take blood from a vein. Therefore, to avoid delays in treatment, it is my opinion that it was reasonable to administer antibiotics to BR, even if the blood culture had not been able to be taken at the time*
>
> *Bacterial infections in general are more likely to cause serious illness than viral illnesses. It is possible that BR had a bacterial infection that was unable to be 'proved' on testing. It is possible that giving antibiotics before the blood cultures were taken made the blood cultures less likely to show anything. However, the early administration of antibiotics (and decision to give them before the blood culture was taken, in view of the difficulties in getting the blood taken) was very reasonable under the circumstances."*

52 The Professor also noted, "*To my knowledge, the coronavirus is not associated with serious illness or cardiac arrest in children, so it is difficult to state that this caused BR's death".*

53 On 11 February 2025, when I had indicated to the family that I would hand down findings on that day, BR's father wrote to the assisting sergeant, forwarding a letter from CMC Lawyers, which referred to comments by a Professor Raftos.

54 It would appear Professor Raftos had been briefed to provide an opinion as an emergency physician, as BR's father was taking advice as to whether a civil action could be taken in relation to BR's death. The letter from CMC Lawyers to BR's father is dated 8 August 2023.

55 The letter set out that Professor Raftos had held a conference with an unidentified counsel (barrister), and reportedly advised, as follows:

(1) Professor Raftos was of the opinion that Manning Base Hospital should have performed a blood test to make sure BR didn't have a bacterial infection, they also, potentially, should have admitted BR.

I take that to be a reference to the first attendance at Manning Base Hospital.

(2) Professor Raftos noted an elevated enzyme in the blood test performed at the John Hunter Hospital. He noted that, "When this enzyme is elevated, it is associated with a viral infection of the heart".

Professor Raftos was said to be somewhat surprised that this wasn't addressed in the autopsy report.

(3) The blood test at the John Hunter Hospital did not reveal either a bacterial infection or a viral infection.

(4) Professor Raftos was said to note that, "If BR was suffering from a bacterial infection, when he first presented to Manning Base Hospital, you would expect for it to show up in the blood tests at the John Hunter Hospital". Contrastingly, with testing for viral infections, they can't test for all known viruses, so it is possible that there was a viral infection that just didn't show up on the testing. Unfortunately, if it was a viral infection (which appears likely then nothing could have been done. Viral infections do not respond to antibiotics. Even if BR had been admitted to the Manning Base Hospital, it would not have changed the outcome".

(5) *It does not appear to have been a bacterial infection due to the fact that one was not detected on the blood test at the John Hunter Hospital. Therefore, the failure to perform blood tests and/or treat for a bacterial infection would have had no impact on the outcome.*

56 I note that Professor Craig had expressed the view that the antibiotic given to treat a bacterial infection may have masked the existence of a bacterial infection. However, Professor Craig confirmed that the antibiotic given was appropriate for such treatment. Professor Raftos' comments tend to indicate there was no causative negligent treatment of BR and BR may have had a viral infection. In fact, Professor Raftos considers it likely that BR had a viral infection which could not have been detected and about which nothing effective could have been done.

57 Following receipt of BR's father's letter of 11 February 2025, as a matter of completeness, Dr Prinsloo was asked to address matters that BR's father had raised. Dr Prinsloo noted in her response of 1 April, *"(1) Professor Raftos had not identified the enzyme to which he had referred. (2) It was not a forensic pathologist's role to comment on testing performed at a hospital. (3) Doctor (Prinsloo) had not tested for all known viruses"*. I add here that Professor Raftos had said, *"...they can't test for all known viruses"*.

58 Dr Prinsloo added, *"If BR had a virus that resulted in the cause of his death, I would have expected to see underlying histological changes in the tissue samples. This was not present at post-mortem examination"*. Earlier, Doctor Prinsloo in her response had said, *"It should be noted that no features of viral myocarditis were identified with post-mortem examination, including the microscopy of the heart"*. Myocarditis is inflammation of the heart muscle caused by viral infection.

59 Dr Prinsloo expressed the view, as had Professor Craig, that administration of Ceftriaxone could have reduced the likelihood that a bacterial infection would be detected.

60 Arising from BR's father's correspondence, it was raised with Dr Prinsloo in writing that in the forensic review by Dr Ella Sugo, there is a misspelling of BR's surname.

61 I note that on the document where the misspelling occurs there is then a number. There is then a reference to DOFM, (Department of Forensic Medicine), Newcastle, and microscopic sections labelled BR (with BR's surname incorrectly spelt), and then a number. I note that the number is the correct DOFM case number. That is, Dr Sugo was referring to the correct Department of Forensic Medicine case number.

62 The question then posed to Dr Prinsloo was, "*Is it likely that this misspelling caused any confusion or issues with the testing or analysis in BR's matter*?"

63 I note that BR's father is very concerned that the reference to (the misspelt surname) is indicative of a mix-up in the sense that BR's sample may have been confused with another person's sample or even that there may be some form of cover-up in relation to the examination of microscopic samples.

64 Indeed, the concern of there being a cover-up of some form runs through BR's father's correspondence. He is fearful that there has been some attempt to hide the impact or potential impact of vaccination upon BR.

65 Dr Prinsloo responded to the question posed to her as follows: "*The name indicated on the report from Dr Ella Sugo was a misspelling of the name of the deceased. There is, in my view, no reason to suspect any issues with the diagnosis made by Dr Sugo as we reviewed the histology slides together".*

66 I again note that Dr Sugo referred to the correct forensic medicine number.

67 I would like to assure BR's father and everyone else associated with BR that I have not seen any document of any nature that would suggest that the reference to (the misspelt surname) was anything other than a misspelling.

68 The final question asked of Dr Prinsloo as a result of BR's father's correspondence was as follows, "*In the post-mortem toxicological analysis, salicylic acid was detected in BR's urine. Could you please explain the significance of this finding*?"

69 At p 5 of the post-mortem, Dr Prinsloo referred to salicylic acid detected in the urine, and in the comments section below that reference noted as follows, "*Toxicology detects no alcohol or commonly screened-for drugs in the blood sample. Salicylic acid is detected but not quantified on the urine sample. The latter, that is the salicylic acid, does not contribute to the cause of death.*

70 Dr Prinsloo's response was sent very belatedly to BR's father and others. The delays since the hearing in 2023 are a result only of workload at the Coroners Court. Those delays are deeply regrettable. When Dr Prinsloo's correspondence was sent to BR's father on 3 October 2025, BR's father responded by posing nine numbered questions. I do not propose to respond to each of them in order, despite BR's father requesting that that be done. Included in that correspondence, BR's father said:

> "*If I had been provided with the report from Forensic Medicine when it was completed (as indicated by its April date) and given a reasonable time period to respond rather than only ten days, three of which were a long weekend, I could have compiled all relevant information and evidence for consideration*

earlier. The delay in receiving that report has significantly impacted my ability to respond effectively."

71 I again express my regret for the delay in providing that report to family members.

72 It is my view that BR's father has been extended every opportunity to respond at each step of the coronial process including since the hearing. The point has come where my findings must be delivered.

73 In the recent correspondence BR's father posed several questions in relation to enzymes and enzyme testing and questions about bacteria and viruses. To some extent, BR's father's questions regarding the enzymes seem not to acknowledge that it was Professor Raftos, (the expert retained by CMC lawyers) rather than Dr Prinsloo, who had first raised issues in relation to an observed enzyme. The responses in relation thereto have been set out above.

74 In relation to the bacterial infection, BR's father wanted to know what signs of previous bacterial infection there may have been in any organ, that is, whether any infection existed prior to BR suffering his terminal cardiac arrest. Any prior bacterial infection was not a matter pursued by the forensic pathologist as it is not a matter relevant to the coronial findings. Questions about Manning Base Hospital administration of antibiotics have also been attended to earlier in these findings.

Is there a need for any Recommendations

75 The next stage of the findings is to consider whether there is a need for any recommendations.

76 Given the steps taken by Manning Base Hospital in relation to the audits, setting up a system in relation to the approach to be taken to ED calls, and adoption of the febrile child guidelines, I do not see the need to make any recommendations about any systemic health issue or any other issue.

Findings under s 81 of the Coroners Act:

77 Having considered all the evidence, it unfortunately remains the case that the cause of BR going into cardiac arrest remains unascertained. As Dr Prinsloo set out in her oral evidence, the cardiac arrest leading to anoxic brain injury from lack of oxygen is the ultimate <u>mechanism</u> of death. What has not been established is what put that train of events into motion, which as a coroner, it is my responsibility to explore. What put that train of events into motion remains unascertained. Was it an epileptic event? Was

it a cardiac event? Was it a virus? Was it a bacterial infection? Was it a reaction to the vaccine? Despite everyone's efforts, it has not been possible to determine the cause of the events leading to BR's cardiac arrest. All of these possible causes are considered to be natural medical events and as such the manner of BR's death is best described as "natural causes".

78 The findings I make under section 81(1) of the Coroners Act 2009 (NSW) are:

Identity	The person who died is BR
Date of death	BR died on 29 July 2020.
Place of death	BR died at John Hunter Hospital, Newcastle
Cause of death	The cause of BR's death is unascertained
Manner of death	BR died of natural causes.

Conclusion

79 I would like to thank BR's family for their involvement in the inquest. I think Professor Craig expressed it perfectly when he, at the end of each of his reports, wrote: "Sudden unexpected death in a young child is a tragic and rare circumstance."

80 My sincere condolences are extended to all the family, extended family and friends. This has been a long, long road, and of course, the underlying cause remains unascertained. Despite that, I hope the process has been, in some way, helpful.

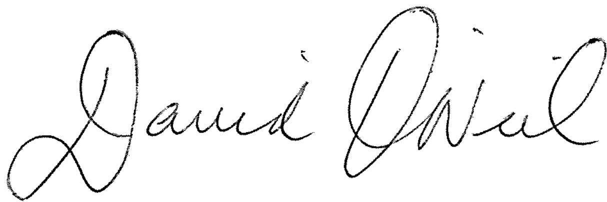
81 I thank Detective Senior Constable Johnson for putting the brief together and staying the distance with this long process, which has involved, as I have set out, much after the hearing in October 23.

82 My thanks also to Sergeant Chytra who, similarly, has stayed the course, both with the initial coroner working hard in preparation for the hearing, in which I ultimately sat, and

the dealings subsequent in ongoing efforts to try and answer the questions raised by the family and see if there was any other area of investigation which needed to be pursued.

83 As Dr Prinsloo and Professor Wood said in evidence, their encouragement remains for the family to undertake genetic testing, as that is the only form of further testing that could helpfully be undertaken.

84 I close this inquest



Magistrate David O'Neil

Deputy State Coroner

20 October 2025