FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

MASTER T

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Master T, with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Date

12 March 2021

Counsel Assisting

J Ansell

Introduction

1. Master T died on 6 August 2019, aged just three, at the Royal Hobart Hospital (RHH).

2. Master T's death is subject to the *Coroners Act* 1995 (the "Act"). The Act provides that an inquest must be held where a death occurs in Tasmania and the deceased person was, immediately before their death, a person held in care.

3. When he died, Master T was the subject of a Care and Protection Order until the age of 18 years made under the provisions of the *Children, Young Persons and their Families* Act 1997. As a consequence, an inquest in relation to his death was mandatory. The investigation and inquest focused upon his care, treatment and supervision.

4. On the basis of the evidence tendered at the inquest I make the following formal findings pursuant to section 28 (1) of the *Coroners Act* 1995:

    (a) The identity of the deceased is Master T;
    (b) Master T died in the circumstances set out further in this finding;
    (c) The cause of Master T's death was hypoxic brain injury secondary to a cardiorespiratory arrest; and
    (d) Master T died on 6 August 2019 at the Royal Hobart Hospital, Hobart, Tasmania.

Background

5. Master T was the biological child of Ms I and Mr G. Ms I and Mr G had three other children. Ms I also had two other children from a previous relationship.[1]

6. During the pregnancy, Master T was identified as having multiple deficits in-utero. He was born at 36 weeks, severely disabled. He spent most of his first year of his short life in either the Royal Hobart Hospital or the Royal Children's Hospital in Melbourne.[2]

7. Master T was discharged home briefly to the care of his parents, who had received training and support in learning Master T's daily care needs. However, Master T did not do well at home. His health deteriorated, and he lost significant weight. He received further care in hospital and Master T's parents were assessed to be unsuitable in caring for Master T. As a consequence, Master T was taken into protective custody by Child Safety Services and provided with a carer who is experienced in caring for children with complex medical needs.[3]

8. On 24 December 2016, Mrs J became Master T's primary carer. She remained so for the rest of his life. Her devotion to Master T continued after his death and was demonstrated by the fact that she attended his inquest.

Health

9. Master T was born with multi-systemic disabilities which included being born without an anus or oesophagus. His medical diagnosis included:

    (a) Intermittent squint;

    (b) Inguinal hernia which was repaired and required ongoing monitoring;

    (c) Anal atresia which required the use of a colostomy bag with ongoing daily stoma care;

    (d) Recurrent urinary tract infections as a result of his medical conditions;

    (e) Lobar type holoprosencephaly with obstructive CSF flow that resulted in surgery to place a VP shunt and required daily monitoring of Master T for any potentially life threatening illness such as influenza or the common cold;

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[1] Exhibit C 8 – medical records.
[2] *Supra*
[3] *Supra*

(f) Neurosurgical issues included a tethered cord with partial sacral agenesis and spinal cord syrinx which required ongoing monitoring, therapy and surgery as he aged; and

(g) Oesophageal repair and oral adversion which resulted in a percutaneous endoscopic gastrostomy to allow PEG feeding (Master T was fed by tube until March 2018).[4]

10. Self-evidently, Master T's care was extremely complicated. By way of example, Master T's feeding schedule involved 100mls administered slowly over a one hour period non-orally via a PEG. The PEG had to be flushed clean immediately prior to, and after, the administration of his food. Mrs J had to measure the quantity to be taken which was then automatically administered by a control pump. The pump had to be set with the quantity and time period over which the feed is to occur. The process needed to be supervised to ensure fluid was flowing freely. Master T was then required to have a one hour break before feeding again. The routine was repeated throughout the day.[5]

11. In addition to the physical disabilities, Master T was developmentally delayed in all areas. In 2018, Master T (2-3 years of age) was estimated to have:

(a) Cognitive problem solving skills at an approximately 9 month old level;
(b) Communication skills at around a 9-12 month old level; and
(c) Motor skills at around a 6-9 month old level.[6]

12. It seems to me that Mrs J did a remarkable job with Master T. It is evident that his life was supported and positive, making a number of advances that were not expected to occur due to his medical conditions. By way of example, Master T was able to crawl and walk around furniture.[7] In short, he thrived in her care.

13. Medical support was consistently provided by Mrs J's family. Master T regularly attended the Royal Hobart Hospital for scans and to meet with the paediatrician to monitor his conditions.[8]

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[4] *Supra*
[5] *Supra*
[6] *Supra*
[7] Exhibit C 10 – Affidavit of Mrs J, sworn 4 September 2019.
[8] *Supra*

The Events Leading up to Master T's Death

14. On Wednesday 31 July 2019, Master T was miserable and generally unwell. He was not keeping his food down and vomiting from time to time. Mrs J gave him Panadol and monitored him generally.[9] His condition remained generally stable for the next couple of days.

15. By Saturday 3 August 2019, although Master T did not have a temperature, his general demeanour had not improved and Mrs J arranged for Master T to attend hospital.[10]

16. The medical record at the Royal Hobart Hospital contained an acute presentation plan to guide assessment and treatment. Notes indicated that Master T had a 2-3 day history of unwellness with increased irritability, lethargy and feed refusal. Master T looked uncomfortable with abdominal pain. There was no fever. PEG feedings continued, the urine output was good and the colostomy was functional.[11]

17. The paediatric team was contacted and decided to review Master T before tests were performed. Master T was reviewed by the paediatric registrar and discussed with the consultant paediatrician. A CT scan of his brain showed a stable brain image. Blood count showed a slightly elevated white blood cell count. Urine test results were to be followed up and antibiotic prescribed if needed. Master T was discharged.[12]

18. Upon returning home Mrs J made a bed on the couch for Master T. Mrs J continued to provide Master T with fluids while checking on his temperature. Mrs J fell asleep next to Master T whilst she was watching a movie.[13]

19. At approximately 1.00am on Sunday 4 August 2019, Mrs J noted a change in Master T's breathing. She described him as 'gurgling'. She noticed that Master T had vomited and was wet to touch. Mrs J moved Master T and he gasped. Mrs J comforted Master T by patting him on the back and immediately called the ambulance.[14]

20. Whilst waiting for the ambulance, Mrs J was guided to perform CPR on Master T. She continued until Ambulance officers arrived and took over. Master T was eventually stabilised[15] and rushed to the RHH. Master T was admitted to the RHH paediatric intensive care unit.

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[9] *Supra*
[10] *Supra*
[11] Exhibit C 6
[12] *Supra*
[13] *Supra*
[14] Exhibit C 10
[15] *Supra*

21. Over the following days, Master T had several tests conducted. They showed that Master T, during respiratory distress, had suffered severe hypoxic brain damage and on 6 August 2019 at 3.00pm, Master T was pronounced brain dead.[16]

22. He was approved for organ donation and organs taken from him helped improve the lives of others in our community.

Investigation

23. The fact of Master T's death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified[17] and then transferred to the RHH mortuary. At the mortuary, Master T's body was examined by Forensic Pathologist, Dr Jane Vuletic MB ChB FRCPA. Dr Vuletic also reviewed Master T's medical records. She provided a report which was tendered at the inquest[18] in which she said:

> *"The cause of death of [Master T], was hypoxic brain injury secondary to a community cardiac arrest, possibly secondary to sepsis.*
>
> *Examination of [Master T] showed appearances consistent with his medical history and treatment in hospital. There was no evidence of violence. His body weight was low at 11.2 kg however was consistent with his multiple chronic medical conditions".*

24. Master T's medical care and treatment was reviewed by Dr Anthony J Bell MB BS MD FRACP FCICM, Medical Advisor to the Coronial Division. Dr Bell provided a report (which was also tendered at the inquest[19]) in which he said:

> *"The care from antenatal care to death appears to be attentive and competent in an extremely difficult case. The patient had significant congenital abnormalities and required a huge effort to fix and repair what could be done.*
>
> *The final event was probably aspiration pneumonitis. The assessment and discharge from RHH the day prior seems appropriate medical care. The doctors recognise the child was at high risk. The placing of a care plan in the medical records was sound management.*
>
> *The foster mother appears to have done an excellent job in a very difficult position"*

25. I accept the opinion of both doctors. They are experienced in their field and well qualified to express the opinions that they have.

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[16] Exhibits C 6, C7 and C 10
[17] Exhibit C 2
[18] Exhibit C 3
[19] Exhibit C 6

Conclusion

26. The evidence tendered at the inquest satisfies me that Master T was appropriately treated and cared for while he was a "person in care" in terms of the *Coroners Act* 1995.

27. I find that the care and treatment of Master T was appropriate, attentive and competent in a difficult medical case. Master T had significant congenital abnormalities and required constant medical intervention.

28. The assessment and discharge from the RHH before his death was, in Dr Bell's view (which I accept), appropriate medical care.

29. The care Master T received from Mrs J was entirely appropriate. Master T thrived under her care. She did a remarkable job in a very difficult position.

Comments and Recommendations

30. In the circumstances there is no need for me to make any further comment or recommendations.

31. In concluding, I convey my sincere condolences to all those whose lives were touched by Master T.

Dated 19 March 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner