MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Simon Cooper, Coroner, having investigated the death of PY

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is PY;
b) PY died in the circumstances set out further in this finding;
c) The cause of PY's death was sepsis leading to multiple organ failure syndrome; and
d) PY died on 23 September 2019 at the Royal Hobart Hospital Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into PY's death. The evidence includes:

- Police Report of Death for the Coroner;
- Medical records – Tasmanian Health Service;
- Medical records – General Practitioner;
- Affidavit – Dr Donald MacGillivray Ritchey, State Forensic Pathologist;
- Final Root Cause Analysis Report – Tasmanian Health Service; and
- Report for the Coroner – Dr Anthony J Bell, Medical Advisor to the Coronial Division.

I have also had specific regard to information provided by the family by email in relation to the circumstances of PY's death.

In addition, these findings, in draft, were sent to the Royal Hobart Hospital for comment. Comment was received, to which I have had specific regard. Those comments seem based, at least in part, on a misapprehension that the findings and observations which follow were based in the main on Dr Bell's report. They were not; rather, these findings were informed, to a very

large extent, by the Final Root Cause Analysis (RCA) report of the Tasmanian Health Service. The Tasmanian Health Service, of course, operates the Royal Hobart Hospital.

I did not understand the Tasmanian Health Service to dispute the conclusions reached in its own RCA.

Background

PY was born two weeks premature, on 6 August 2019 via caesarean section to his mother. Immediately after his birth, PY was transferred to the Royal Hobart Hospital's Neonatal Intensive Care Unit (ICU). He was diagnosed as suffering a congenital heart defect, that is to say, a small to moderate atrial septal defect and mild pulmonary stenosis. PY remained in the Neonatal ICU for approximately six days suffering from respiratory difficulties before he was discharged to the care of his parents, at their home in New Norfolk.

Circumstances of Death

On 17 September 2019, PY received his six week vaccination.

Three days later, just after 8.00am on 20 September 2019, PY's parents took him to their regular GP with a fever and vomiting. A blood test was ordered and a prescription for antibiotics provided, with instructions that the antibiotics were to be given if PY had not improved by about 6.00pm that evening.

Unfortunately, PY quickly deteriorated and so his parents took him to the Royal Hobart Hospital Emergency Department (ED), arriving there just before noon. PY was irritable and crying. He was triaged as Category 3 (a categorisation that requires a patient to be reviewed by a medical officer within 30 minutes).

In fact, PY was not seen for 51 minutes, and then only by an ED intern. I observe that an intern is a doctor who has completed a medical degree at University and is engaged in their first year of practice, under supervision.

In any event, PY's medical records indicate that at 1.00pm observations were recorded in what is described as a Children's Early Warning Tool (CEWT), paperwork used to track a paediatric patient's vital signs. PY's CEWT 'score' initially was 7. According to the Tasmanian Health Service Root Cause Analysis, a score of 6 to 7 requires, among other things, a patient to be reviewed within 15 minutes and a full CEWT assessment to be conducted. Neither of these

things happened. PY's initial score also required the taking of full blood pressure. PY's blood pressure was not taken until 7.15pm.

The CEWT required documented interventions to be recorded. No such interventions are documented anywhere in his medical record.

At 1.38pm, an ED consultant (I note ***not*** a paediatrician) reviewed PY. Medical records indicate that sepsis was now considered as a possible diagnosis and a plan for treatment by the administration of IV antibiotics as soon as possible and admission under the paediatric team was formulated.

According to both the Root Cause Analysis and PY's medical records, full observations were not recorded and paracetamol was given to PY while he was waiting to be seen by a paediatric medical officer.

That review occurred at 3.00pm. PY's medical records record that the paediatric registrar was unable to achieve IV access and PY was admitted to the paediatric unit (although he physically remained in the ED).

His condition continued to worsen and at 3.40pm minimum CEWT observations documented a score of 5. At 4.30pm, his records indicate a phone call was made to chase up the results of a heel prick blood sample. Those results were not then available.

PY was seen by a paediatric consultant at 5.00pm. IV access remained unsuccessful. The Neonatal Paediatric ICU was contacted to arrange for the attendance of a senior registrar and/or consultant to attend to assist in relation to IV access.

PY continued to deteriorate. By now his CRP was 99 mg/L, suggesting he had a bacterial infection. An abdominal x-ray, carried out at about 5.34pm, showed PY had a distal bowel obstruction and a blood test carried out shortly after was consistent with severe sepsis. An abdominal ultrasound confirmed the bowel obstruction and a decision was made to operate.

During surgery, a large bowel stricture was found. PY's bowel was surgically resected and he was then transferred to the hospital's ICU. Unfortunately, his condition continued to deteriorate and he developed multiple organ failure syndrome. There was no improvement in his condition despite all appropriate major interventions, organ support and relook surgery. He died, aged just 48 days, on 23 September 2019.

Investigation

The fact of PY's death was not reported initially in accordance with the requirements of the *Coroners Act* 1995. Ultimately, some months later, a report was received, and the circumstances of PY's death were reviewed by the Coronial Division's Medico-Legal Committee.

Conclusion

That investigation leads me to conclude, first, that PY's initial triaged assessment at Category 3 was wrong. He needed to be seen much sooner than 30 minutes (even though he was not, in fact, seen for nearly an hour).

Second, his management thereafter was informed by medical staff apparently not believing that his condition required urgent or time critical treatment until about 6.00pm (six hours after his arrival in hospital and by which time it was almost certainly too late to save him).

It seems that the knowledge of his congenital heart condition may have served to obscure the reality of what was happening to PY, that is that he was suffering from a life threatening bacterial infection.

I make two other brief observations in relation to this sad case in closing. First, the Solicitor General, on behalf of the Secretary of the Department of Health, appears to dispute (but without explaining why) my conclusion that PY's death was not initially reported in accordance with the requirements of the *Coroners Act* 1995. PY died on 23 September 2019. His death was not reported until his parents drew the attention of the Coronial Division to the fact of PY's death towards the end of November of the same year. Because there was a delay in reporting his death there was, necessarily, a delay in investigating. Sometime was taken in seeking advice from the State Forensic Pathologist as to whether an order should be made to exhume PY's body to assist in that investigation. That would not have occurred had the fact of his death been reported earlier.

Second, the Solicitor General submitted that should I "propose to make the adverse factual findings contained in the draft record, notwithstanding this response, my instructors respectfully seek an opportunity to provide evidence". I do not require any additional evidence to assist me to make the findings required by section 28(1) of the *Coroners Act* 1995. As should be apparent in this finding, the conclusions I have reached have been guided, in the main, by the Royal Hobart Hospital's own RCA.

Comments and Recommendations

The circumstances of PY's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of PY.

Dated 26 August 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner