FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 2610/07

Inquest into the Death of JACINTA MEGAN PASCOE

Delivered On:	3rd September 2010
Delivered At:	Level 1, 436 Lonsdale Street, Melbourne
Hearing Dates:	13th July 2010
Findings of:	HEATHER SPOONER
Representation:	Mr P Halley - Austin Health Mr E Gardner - Ambulance Victoria
Place of death:	Austin Hospital, 145 Studley Road, Heidelberg Victoria 3084
Police Coronial Support Unit:	Leading Senior Constable King Taylor

FORM 37

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FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 2610/07

In the Coroners Court of Victoria at Melbourne

I, HEATHER SPOONER, Coroner

having investigated the death of:

Details of deceased:

Surname: PASCOE
First name: JACINTA
Address: 100 Delta Road, Greensborough, Victoria 3088

AND having held an inquest in relation to this death on 13 July 2010 at Melbourne

find that the identity of the deceased was JACINTA MEGAN PASCOE
and death occurred on or about 10th July, 2007

at Austin Hospital, 145 Studley Road, Heidelberg Victoria 3084

from
1a. MYOCARDIAL INFARCTION

Brief Background

1. Jacinta was just four weeks old when she died. She was born prematurely at 36 weeks gestation on 7 June 2007 at the Mercy Hospital. Jacinta was discharged five days later to reside at home in the care of her parents, Allan and Bronwyn Pascoe.

2. An investigation into the circumstances surrounding the death revealed that on 9 July 2007, Jacinta seemed unwell and consumed less than her usual quantity of expressed breast milk. That evening her health declined and her parents telephoned the 'Nurse On Call' service and were advised to call an ambulance. Jacinta was transferred to the Austin Hospital but her condition continued to deteriorate and she died in the early hours of the following morning.

Family concerns

3. Mr & Mrs Pascoe expressed some concerns about the ambulance attendance, transfer and emergency treatment at the Austin Hospital. They raised several issues including an alleged failure by paramedics to take observations enroute to Hospital, the Hospital policy regarding newborn infants in the Emergency Department and communication and handover between the Paramedics and Hospital staff. At the Inquest Mr & Mrs Pascoe indicated through the Coroner's Assistant, Senior Constable Taylor, that their main concern related to the ambulance transfer. These matters, together with the cause of death, were the focus of the inquest.

Autopsy

4. An Autopsy was performed by Dr Katherine White, Forensic Pathologist and former employee at Victorian Institute of Forensic Medicine. In her report, Dr White formulated the cause of Jacinta's death as *'myocardial infarctions'* due to *'probable fibromuscular dysplasia'*.

Evidence at Inquest

5. **Dr Burke** told the inquest that he had reviewed the Pathology report, histology slides and Dr Chow's 'Review of VIFM Case No. 2610/2007' report. In that report Dr Chow who is Director of Pathology at the Royal Children's Hospital, stated in part:

> *"Review of the histology of the autopsy on Jacinta Pascoe showed extensive focal areas of infarction involving the myocardium. The changes of infarction are well developed with focal fibrosis and calcification. This suggests that the lesion is of at least several days duration. The cause of this infarction is not clear. In this age group anomalous origin of the left coronary artery has to be considered but this was not noted at autopsy. One section of the myocardium shows a branch of the coronary artery on the epicardium with a segmental area of thickening in the form of a bulge. The internal elastic lamina is disrupted under this area. The lesion is composed of a mixture of myxiod ground substance, thin elastic fibres and smooth muscle fibre. There is only mild decrease in the lumen of the coronary artery. The features are suggestive of an intimal cushion, a normal structure in infants and young children at the site of arterial branching. The features are not strongly suggestive of fibromuscular dysplasia. Review of the other organs did not show any convincing evidence of an arterial disease or any other major abnormality.*
>
> *The cause of death is myocardial infarction. The cause of this remains unclear."*

Had Dr White known of Dr Chow's report, Dr Burke believed she would have issued a supplementary report as it was his view that the death should be based on Dr Chow's opinion with the cause of the myocardial infarction remaining unclear.

6. Dr Burke told the inquest about a number of *'insults'* to Jacinta's heart that could have occurred over a period of days leading up to her death. Although Jacinta may have seemed unwell, the actual insults may not have been obvious until the day prior to her death when she was limp, grunting and pale. It was his opinion that at that stage, *"it had become symptomatic and from that point I don't see that anything could have been done."*

7. **Ms Tarryn Gooding**, Ambulance Paramedic, gave detailed evidence about what occurred during her attendance upon Jacinta. The parental concerns were disputed and she maintained that she had acted appropriately, provided proper management and could not have done more.

8. Ms Gooding told the inquest that the ambulance was initially dispatched as *'time critical.'* Upon arrival, Mrs Pascoe had given a brief history that included a projectile vomit, limpness and grunting sounds. Although Ms Gooding claimed that Mrs Pascoe felt Jacinta had improved, she made no note of it on the VACIS electronic patient care report (PCR) stating in part, *"all I can say is this was new at the time and they are difficult to get used to considering what we came from and it's probably not a good representation of what happened."* She agreed that she should have entered important information. Her evidence about the assessment of Jacinta's Glasgow coma score was questionable. She determined Jacinta's condition to be sufficiently urgent to proceed to hospital however, the dispatch code was downgraded.

9. Although Ms Gooding told the inquest that she had only recorded the administration of oxygen en route to hospital, she maintained that she also performed observations on Jacinta including listening to her heart rate via a stethoscope and respirations. Ms Gooding agreed that these observations were not recorded and when asked why not, she stated, *"..I would say VACIS that was just introduced was new and given that there wasn't any change in her observations I have omitted them.."* Ms Gooding clearly had some difficulties with this newly introduced computerised PCR, which she indicated had since been improved.

10. When questioned about the Hospital handover process Ms Gooding stated that she had to wait for someone to attend the triage desk. She could not recall having told the nurse that the baby had cyanosed lips, nor using the terminology *'chucking baby'*. She believed that Mrs Pascoe would have been able to view where she was and she disagreed with the nurse that she could not see the baby. There was some issue with the triage nurse trying to locate a bed but when Jacinta was taken to a second resuscitation room she was promptly attended to by both nursing and medical staff.

11. Mr & Mrs Pascoe lodged a complaint, but an internal Clinical Case Review by Ambulance Victoria found Ms Gooding had acted appropriately.

12. **Ms Kathryn McIlroy** was the triage registered nurse on duty in the Austin Hospital Emergency Department on this particular evening. Ms McIlroy stated that when she asked Ms Gooding why the patient had been asked to wait past the triage point *"she explained that they had brought in another 'chucking baby'."* After listening to the history and observations she asked 'where is the baby?' Although Ms McIlroy did not examine Jacinta and gave her a category 2 triage (which she claimed was just a "typo"), she maintained that Jacinta was treated as a category 1 patient. The triage documentation was completed and handed to a nurse who immediately paged for a doctor.

13. There was an issue around locating an available resuscitation room for Jacinta however that was later resolved. Nurse McIlroy told the inquest that babies were assessed and triaged in the same way as adults and when asked if there was anything that could have been done better she stated, *"..Well at the time that resuscitation room was not staffed overnight, so therefore it was closed as such, however I just opened it up and pulled staff out to go and look at the baby. So to have more staff on to be able to open up every area that we hav,e which now is the case, we have staff on to staff it 24 hours a day ".*

14. **Dr Joanne Brown** was the Emergency Physician working at the Austin on this particular evening. She assessed Jacinta to be unwell; floppy, not breathing well with poor coloured skin. Dr Brown attempted to gain intravenous access. She also tried to contact a neonatal intervensionist and then tried the Neonatal Emergency Transport Services (NETS). Dr Brown was assisted by two other doctors in attempting to gain access and insert a cannula as part of the treatment process. Dr Rogerson, NETS Consultant, arrived and assessed Jacinta as requiring intubation and discussed the situation with her parents. Despite ongoing attempts at resuscitation Jacinta's heart rate slowed and further CPR was commenced. Dr Brown had since seen both the autopsy report and the report of Dr Chow and could not think of anything more that could have been done to improve the outcome for Jacinta.

15. Dr Brown told the inquest that changes had been implemented following reviews arising from Jacinta's death. The Austin Emergency Department now had a fully staffed second resuscitation room and a single point of contact for a neonatal consultant at the Mercy Hospital which provided an integrated service with the Austin *"..so that there's a better paediatric and neonatal skills in the staff at the Austin..".* In regard to other changes she stated that *"..we probably have a better ambulance communication system now because we- well, the ambulance service has installed a radio so that we can have direct contact with the cars in which the patients are travelling. Previously all contact went through the ambulance control service and came by telephone. "* Had those improvements been in place when Jacinta presented to the Austin

Hospital Dr Brown stated *"..I don't think they would have made a difference to Jacinta's outcome. They might have made things smoother for the staff and the parents."*

16. By letter dated 19 July 2010, Dr Simon Judkins, Acting Director Emergency Medicine, detailed a number of changes since Jacinta's death including:

- *access to and staffing of resuscitation rooms overnight*
- *access to advice and assistance from Mercy Hospital Neonatal specialist staff*
- *interosseous access devices*
- *neonatal training/teaching*
- *paediatric staff*
- *direct ambulance communication with ED*

He concluded: *'It is hoped that these changes will improve outcomes and decrease stress in all involved in cases similar to Jacinta's in the future.'*

Findings

17. I find that Ms Gooding may not have fully appreciated the gravity of Jacinta's condition. There were some shortcomings in her evidence including her record keeping and failure to note down Jacinta's observations en route to the Emergency Department. Whilst she disputed Jacinta's parents concerns, she was also at odds with aspects of Nurse McIlroy's evidence. Fortunately, the difficulties that Ms Gooding stated she experienced with the introduction of the VACIS patient care report system have apparently since resolved.

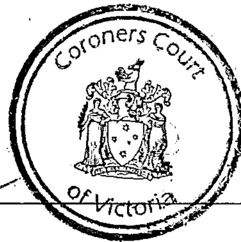
18. I find that whilst some of the processes surrounding Jacinta's attendance at the Austin Hospital Emergency Department were far from ideal, the attending nurses and clinicians did everything they could to try and save her. The Hospital has since responded and reviewed the situation and appropriate improvements have been introduced.

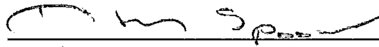
19. I find that the reference to *'fibromuscular dysplasia'* as part of the cause of death referred to in the Autopsy Report should be deleted and I have amended the cause of death accordingly, having regard to the Autopsy Report, the Review by Dr Chow and the evidence of Dr Burke.

20. I find that Jacinta suffered severe myocardial damage and died from myocardial infarction.

21. I find it unlikely that any other intervention by paramedics, nurses or clinicians would have altered the ultimate outcome and Jacinta's unfortunate demise.

Signature:





Heather Spooner
Coroner
3 September 2010