IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 2659

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	BABY C
Date of birth:	24 December 2017
Date of death:	5 June 2018
Cause of death:	1(a) Myocarditis
Place of death:	Sunshine Hospital, Furlong Road, St Albans, Victoria

HER HONOUR:

Background

1. Baby C was born on 24 December 2017. He was five months old when he died on 5 June 2018 from myocarditis.

2. Baby C was the much-loved son of Mr P and Mrs P, and brother of Sibling S. The family lived in Delahey at the time of his death.

3. Baby C was born at 37-weeks-and-six-days gestation via normal vaginal delivery at the Royal Women's Hospital, Parkville. Antenatally, Mrs P was diagnosed with gestational hypothyroidism.[1] Both Mr and Mrs P were alpha-thalassaemia carriers.[2] Mrs P was reviewed in the Royal Women's Hospital Foetal Medical Unit clinic[3] and advised there was no indication of Baby C having severe alpha-thalassaemia.

4. Baby C weighed 2140 grams at birth. He was assigned normal APGAR[4] scores of eight at one minute and nine at five minutes. In the immediate postnatal period, he was treated for hypoglycaemia.[5] With regular milk feeds, his blood sugar levels normalised.

5. As Baby C was small for gestational age,[6] he was discharged home with reviews of his growth and feeding by the Neonatal Hospital in the Home program. He was subsequently discharged from the program on day six of life after having progressed well. After discharge, Baby C was reported to be thriving and growing normally.

6. On 29 April 2018, Baby C was reviewed by Dr Azin Malekzadeh, general practitioner at Active Medical Centre in Caroline Springs, for his routine four-month immunisations and assessment for a cough. Dr Malekzadeh assessed Baby c to be well enough to receive his immunisations. Baby C did not experience any immediate complications after his

[1] Gestational hypothyroidism refers to thyroid hormone disturbance during pregnancy which may require treatment with thyroxine.
[2] Thalassemia is a genetic disorder that affects the production of haemoglobin, the oxygen-carrying protein in red blood cells.
[3] Sub specialist in perinatal medicine.
[4] The Apgar score was designed to standardize the way caregivers evaluated a baby's physical wellbeing at birth, helping to provide a general understanding of how well each baby makes the physical transition to independent life from their mother. The Apgar score utilizes five physical signs of a baby at birth, with the score usually given by the caregiver when the baby is 1 minute old and again when they are 5 minutes old. However, if the baby takes longer to fully breathe and respond, the scoring may continue, given again at 7 minutes and possibly also at 10 minutes of age.
[5] Low blood sugar.
[6] Small for gestational age infants have birthweight more than two standard deviation below the mean or less than the 10th percentile for the gestational age.

immunisations. Mrs P had reported that other family members had been unwell with cold-like symptoms. The doctor advised Mrs P to manage Baby C with paracetamol and ibuprofen as needed.

The coronial investigation

7. Baby C's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[7]

9. The law is clear that coroners establish facts; they do not cast blame or determine criminal or civil liability.

10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

11. Coroner Rosemary Carlin initially had carriage of this investigation. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Baby C's death. The Coroner's Investigator obtained CCTV footage from the Emergency Department waiting room at Sunshine Hospital. The Court also obtained Baby C's medical records and a statement from the Director of Paediatric Emergency Medicine at Sunshine Hospital.

12. Coroner Carlin then referred Baby C's death to the Coroners Prevention Unit for review of the treatment he received at Sunshine Hospital, which is discussed below.

[7] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

13. In September 2019, Coroner Carlin was appointed to the County Court and I took over carriage of this matter for the purposes of finalising this finding.

14. After considering all the material obtained during the coronial investigation, including the review by the Coroners Prevention Unit, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

15. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

16. Baby C was visually identified by his father, Mr P, on 5 June 2018 Identity was not in issue and required no further investigation.

Medical cause of death

17. On 6 June 2018, Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the body of Baby C and reviewed a post mortem computed tomography (CT) scan.

18. The autopsy revealed myocarditis, congenital mesoblastic nephroma, and mild bronchiolitis.

19. Dr Parsons explained that myocarditis is an inflammation of the heart muscle. It can affect the heart muscle and electrical system, reducing the heart's ability to pump and cause rapid or abnormal heart rhythms known as arrhythmias. The most common cause of myocarditis is a viral infection. It can also be as a result of reaction to a drug or part of a more general inflammatory condition. Signs and symptoms include chest pain, fatigue, shortness of breath, and arrhythmias. In children myocarditis can cause fever, fainting, breathing difficulties, rapid breathing, and arrhythmias. Certain serious arrhythmias can cause sudden death in myocarditis.

20. There are many viruses commonly associated with myocarditis including the viruses that cause the common cold (adenovirus), hepatitis B and C, parvovirus, and herpes simplex virus. Gastrointestinal infections such as Epstein Barr virus, Echo viruses, and Rubella can also cause myocarditis. Dr Parsons noted that in Baby C's case, Rhinovirus and

Cytomegalovirus were cultured from nasopharyngeal aspirate. Evidence of mild bronchiolitis which is in keeping with a viral infection in the lungs.

21. Dr Parsons also noted an incidental congenital mesoblastic nephroma was identified at autopsy. This was an incidental finding and is not related to the cause of death.

22. Toxicological analysis of post-mortem specimens taken from Baby C identified atropine, paracetamol, and flucloxacillin.

23. After reviewing toxicology results, Dr Parsons completed a report, dated 10 October 2018, in which she formulated the cause of death as "*1(a) Myocarditis*" and was of the opinion that Baby C's death was due to natural cases. I accept Dr Parsons's opinion as to the medical cause of death.

Circumstances in which the death occurred

24. On the night of 4 June 2018, Baby C became acutely unwell at home with symptoms of fever, difficulty sleeping, and irritability. His parents also reported that his feet were *"a bit blue"*.

25. His parents gave him paracetamol at 2.00am on 5 June 2018.

26. A few hours later, they decided to take Baby C to the Sunshine Hospital Emergency Department for a medical review because he was lethargic and was not interested in feeding.

27. Baby C and his parents arrived at the Emergency Department at 8.18am and he was assessed by the triage nurse at 8.21am. Baby C had a fever with a temperature of 38.4 degrees Celsius but was assessed to be *"settled in mum's arms"*, *"alert"*, and had *"normal respiratory effort."* Baby C was subsequently assigned an Australasian Triage Scale (**ATS**) category of four.[8]

28. Baby C and his mother thereafter remained in the waiting room as there was no available cubicles in the Emergency Department.

[8] Australasian Triage Scale (**ATS**) is a clinical tool used in the initial triage assessment of patients to determine urgency of medical assessment and treatment. ATS Category 4 indicates a patient is 'Semi-urgent (to be seen) within 60-minutes.'

29. While in the waiting room, Mrs P became concerned about her son and approached the triage staff at 9.52am. After a brief discussion, Mrs P returned to the waiting area at 9.53am.

30. At 9.56am, Mrs P removed Baby C from his sleeping bag. She took him to the toilet at 9.57am at which time she realised he had become more unwell – he was struggling with his breathing and *"was turning blue/purple on his lips."*

31. She took him to the triage desk for a second time at 9.59am. Triage staff assessed Baby C and documented the following at 10.01am:

> *... mum concerned as patient breathing fast. Some WOB*[9] *and ICC*[10] *observed, irritable ... paeds team aware of patient and will bring patient in when bed available.*

32. At 10.02am, a nurse walked out to call Baby C and escorted both him and Mrs P into the paediatric Emergency Department treatment area.

33. Baby C entered the paediatric Emergency Department treatment at 10.10am, which was one hour and 52 minutes after he had arrived at the hospital.

34. As soon as Baby C entered the treatment area, he was reviewed by Dr Taraka Dissanayake, paediatric registrar. Dr Dissanayake promptly assessed Baby C to be critically unwell, likely due to sepsis[11] and at high risk of septic shock.[12]

35. Emergency Department staff took Baby C to the resuscitation area immediately to commenced definitive treatment including insertion of an intravenous (**IV**) cannula. Dr Lucia Le-Kim, an adult Emergency Department consultant, was notified and attended within 10 minutes of Baby C's arrival in the resuscitation room. IV access was secured, and appropriate treatment was commenced promptly according to guidelines for standard septic shock treatment.

36. At 10.39am, Baby C became unresponsive and resuscitation commenced according to the Advanced Paediatric Life Support algorithm. This included airway support, chest

[9] Work of breathing – sign of respiratory distress, displaying increased effort in breathing.
[10] Intercostal contractions – marker of increased effort in breathing.
[11] Sepsis is a potentially life-threatening condition caused by the body's response to an infection that can trigger changes that can damage multiple organ systems.
[12] Low blood pressure or tissue hypoperfusion due to sepsis despite adequate fluid resuscitation.

compressions, inotropic support, and broad-spectrum antibiotics.[13] Additional staff were also called upon to assist in the resuscitation including a second Emergency Department consultant, Emergency Department nursing staff, an anaesthetic registrar, and the inpatient Paediatric team, which included a paediatric consultant and registrar.

37. Staff contacted the Paediatric Infant Perinatal Emergency Retrieval (**PIPER**) team[14] who provided guidance. The PIPER team was dispatched from Royal Children's Hospital and arrived in the Emergency Department at 11.26am.

38. Despite the resuscitation efforts, there was no return to spontaneous circulation at multiple assessments. A discussion between Baby C's treating clinicians and his parents resulted in a decision to redirect care to palliative care at 11.48am and cardio-pulmonary resuscitation was ceased at 11.50am. Baby C passed away at 13.30pm with his parents by his side.

Family concerns

39. In December 2018, Mr P wrote to the Court with his concerns about the treatment Baby C received at Sunshine Hospital. These included:

    (a) the triage nurse did not perform a thorough investigation of Baby C when they arrived at the Emergency Department;

    (b) Mrs P's concern regarding Baby C's condition was not adequately addressed when she informed staff of her concerns and Baby c was not further checked while waiting to be assessed by a doctor; and

    (c) the experience and capability of staff treating Baby C.

40. In light of these concerns, the Coroners Prevention Unit (**CPU**) reviewed Baby C's medical records, obtained a statement from Associate Professor David Krieser, Director of Paediatric Emergency Medicine at Sunshine Hospital, and reviewed Mr P's concerns.

---

[13] Use of inotropic drugs in resuscitation. Inotrope drugs are used to increase the strength of contraction of the heart and peripheral blood vessels Positive inotropic agents increase myocardial contractility and are used to support cardiac function in conditions such as decompensated congestive.

[14] PIPER provides immediate access to a consultant neonatologist for advice about resuscitation and stabilisation. If clinically indicated. PIPER provides a neonatal retrieval team (doctor and nurse) who travel to the referring hospital to further stabilise the baby before transporting to a Melbourne hospital with a paediatric Intensive Care Unit.

41. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

Assessment by triage nurse

42. Baby C's family expressed concern that he was inadequately assessed in the primary evaluation by triage staff upon arrival to the Emergency Department.

43. Baby C arrived at 8.18am and was promptly seen by triage staff on arrival. A triage assessment would routinely consist of obtaining a brief history of presenting complaint from the patient or carer as well as a brief physical examination including measurement of vital signs[15] to determine the urgency of care required.

44. The triage nurse obtained a brief history of the presenting complaint from Mrs P and started to perform a physical examination on Baby C. The assessment included a review of his perfusion or hydration status (normal), respiratory effort (normal), and level of alertness (normal). Baby C's temperature was reported to be 38.4 degrees Celsius, which is consistent with a fever. The triage nurse had attempted to measure Baby C's heart rate and oxygen levels with a pulse oximeter but was unsuccessful as he became distressed with the process, which a common occurrence. Baby C's weight was not measured as this was considered unnecessary at the time, and there were no scales in the triage area. In his statement, Associate Professor Krieser noted that a weight was only considered necessary if medication or treatment is to be commenced.

45. At the triage assessment, based on all the above information, Baby C was assigned a triage category of four.[16]

46. The CPU advised that the triage assessment was suboptimal and may have impacted negatively on patient care. There was an attempt made to measure Baby C's heart rate and oxygen levels, which were unsuccessful the first time. It did not appear that the triage nurse attempted to measure this again a second time, perhaps at a time when Baby C was more

[15] Measurement of physiological parameters including heart rate, respiratory rate, oxygen levels, blood pressure and temperature.
[16] Australasian Triage Network Category 4 – Semi-urgent Within 60-minutes.

settled, or when Mrs P returned to triage with him at 9.52am. These physiological parameters would have been vital in guiding the degree of urgency in his care.

47. Although a measurement of weight is not considered a vital assessment in the triage process, Baby C had a fever at the time of presentation and could have been offered a dose of paracetamol. This may have aided in settling him so that his other vital signs could have been measured. This would have also prompted a measurement of his weight. Given his age, he would have to be weighed naked to obtain an accurate measurement. This would have provided an opportunity for the triage nurse to assess for any important signs (for example, discoloured skin or mottling) in a child presenting with a febrile illness that may warrant more urgent review. His measured weight would have also been helpful in his subsequent management as medications are calculated based on weight in paediatric patients.

Concerns not adequately addressed

48. After the initial triage assessment, Mrs P and Baby C waited in the paediatric Emergency Department waiting room for one hour and 31 minutes. Mrs P then approached the triage desk at 9.52am and later at 9.59am. There is a discrepancy in the reports regarding what happened during this time.

49. In his email, Mr P reported Mrs P approached the triage window at 9.52am, seeking assistance from triage staff. However, Associate Professor Krieser stated that Mrs P had requested an update on how much longer they had to wait. The CCTV footage appears to show that after a brief discussion with Mrs P the triage nurse contacted the paediatric Emergency Department team and relayed the information received to Mrs P. Mrs P returned to the waiting area at 9.53am.

50. At 9.59am, Mrs P approached the triage window a second time as she was concerned with Baby C's condition. In his email, Mr P stated that his wife *"... immediately rushed him to the front desk again, sobbing and pleading for help ..."*. Review of the CCTV footage shows Mrs P approaching the triage window calmly with Baby C and waiting in line behind another patient. After that patient left, Mrs P stepped forward to express her concerns regarding her son's breathing effort and change in skin colour. At this time, the triage nurse performed an assessment of Baby C and documented that he had a normal temperature of

37.2 degrees Celsius but that there was now some increase in his respiratory effort.[17] No other vital signs measurement was taken at this point.

51. The end of this re-assessment coincided with a cot becoming available and a nurse from the paediatric Emergency Department coming out to the waiting room to escort Baby C and Mrs P to the paediatric treatment area at 10.02am.

52. From a review of the CCTV footage and the medical records, it is unclear whether the urgency of Mrs P's concerns was communicated to the triage staff when she approached them at 9.52am and 9.59am.

53. It appears that the triage staff did attempt to address Mrs P's concerns when she re-presented to the triage desk.

Experience and capability of medical staff

54. Mr P expressed concerns regarding the capability of medical staff involved in Baby C's care. The medical staff present at Baby C's resuscitation included two adult Emergency Department consultants, an Emergency Department paediatric registrar, paediatric consultant, inpatient paediatric registrar, anaesthetic registrar, and PIPER doctors from the Royal Children's Hospital. I am satisfied there was adequate medical personnel and expertise to manage the resuscitation.

55. Although there was no specialist paediatric Emergency Department consultant, this is unlikely to have impacted Baby C's outcome as adult Emergency Department consultants are also trained and competent in paediatric resuscitation. The inpatient paediatric consultant was also present at the resuscitation. Additionally, further guidance was appropriately sought from the PIPER team. The steps in resuscitation were appropriate and timely in accordance to the APLS guidelines.

56. Mr P commented he observed medical staff often referring to manuals during the resuscitation. Safety checklists or 'manuals' are commonly used in clinical emergencies.

[17] Evidenced by intercostal recession.

Their use aims to decrease errors and increase teamwork by providing clear instructions on emergency management and pre-calculated medication doses.[18]

57. The CPU advised that an appropriate number of adequately skilled staff were present in the management of Baby C.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Baby C, born 24 December 2017;

(b) Baby C died on 5 June 2018 at Sunshine Hospital, Furlong Road, St Albans, Victoria, from myocarditis; and

(c) the death occurred in the circumstances described above.

Comments

Pursuant to section 67(3) of the Act, I make the following comments connected with Baby C's death:

1. As follows, I am satisfied that a number of contributing factors negatively impacted on Baby C's care. I note that Western Health was provided with a copy of my proposed comments in accordance with the principles of procedural fairness. On 15 September 2020, I received a submission from Dr Paul Eleftheriou, Chief Medical Officer at Western Health, in response to my proposed comments. Dr Eleftheriou's submission has been incorporated below where relevant.

Suboptimal triage assessment

2. The initial assessment undertaken by the triage nurse when Baby C arrived at the Emergency Department was suboptimal. There was no record of any heart rate, respiratory rate, or oxygen saturation level measured at the initial triage assessment. These are routine vital signs that should be obtained at all triage assessments as each parameter has the potential to influence the ATS category and clinical decision-making.

[18] In 2010, World Health Organisation developed the 'Surgical Safety Checklist'. This checklist methodology has since been adopted for use in a number of clinical emergency scenarios, including paediatric resuscitation.

3. It is not unusual for infants and children to be distressed while staff obtain these measurements and initial attempts are commonly unsuccessful. However, there was no further attempt at obtaining the missing vital signs by staff while Baby C was in the waiting room.

4. I acknowledge that it is possible that the triage staff may have been overburdened by the acuity of workload on the day or distracted by newer patients who arrived in Emergency Department given that the same triage staff had to perform initial triage assessment for both adult and paediatric patients. As the day progressed, there was a gradual increasing number of patients presenting to the Emergency Department. Even so, it does not appear that any attempt was made to obtain a complete set of vital signs from Baby C in the one hour and 40 minutes following the initial unsuccessful attempt to the triage reassessment.

5. The triage category assigned to Baby C did not appear to be in accordance to the published guidelines from the Emergency Triage Education Kit (**ETEK**),[19] which is used in staff training and education. Baby C was assigned a triage category of four after his initial assessment. However, he did not have a complete set of vital signs taken and had additional risk factors for serious illness or injury – these additional risk factors were parental concerns and an alteration in body temperature. Given these additional factors, Baby C might have been considered for a higher acuity triage category. Dr Eleftheriou submitted that he was unable to say whether Baby C should have been assigned a triage category of three of four and conceded this was due to an incomplete triage.

6. According to Associate Professor Krieser, Sunshine Hospital's internal review identified that the current Triage Training Program did not appropriately reflect the case mix of paediatric presentations as well as limitations of the physical environment and staffing for adequate triage paediatric assessment in Emergency Department. Several recommendations have been actioned to improve this, including:

   (a) regular education, training and credentialing of triage staff with the standard ETEK. Dr Eleftheriou confirmed the triage education includes initial assessment, recording of vital signs, and specific paediatric considerations such as assessing distressed infants; and

[19] Australasian College for Emergency Medicine "Emergency Triage Education Kit." (Internet, 9 October 2019).https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for- Patients/Triage.

(b) dedicated paediatric triage area and dedicated paediatric triage staff.

7. These recommendations are an appropriate in response to the issues raised above to prevent future recurrences.

Delay in definitive treatment due to treatment cubicles being unavailable

8. On the day Baby C presented to the Emergency Department, the department was 'bed blocked'.[20] Associate Professor Krieser explained that the demands for services across Sunshine Hospital had impacted on the capability of the Emergency Department to accommodate newly arrived patients in a timely manner. All the paediatric cubicles were occupied by inpatients who were waiting for beds to become available in the paediatric ward. Due to the unavailability of the cubicles, Baby C was not reviewed within the recommended timeframe of 60 minutes.

9. This is a complicated but important clinical issue to address. Sunshine Hospital identified this as an issue and had implemented the 'Every Minute Matters' initiative. This initiative outlined a standard operating procedure for the transfer and escalation of all patients from the Emergency Department to an inpatient ward. Dr Eleftheriou confirmed the initiative is no longer operational at Western Health. However, he noted that the appointment of a Director of Access and Patient Flow and the centralisation of Western Health's bed management processes in 2019 have led to additional process improvements that have enhanced risk mitigation strategies associated with delayed access to appropriate care for patients. In March 2019, Western Health also implemented 'Daily Operating Systems' senior leadership meetings to improve care outcomes for hospital patients by solving problems in the moment.

10. I acknowledge that meeting service demands across hospitals is ongoing challenge. The new initiatives implemented at Western Health are a step in the right direction in addressing a complex issue.

Lack of repeated assessment in waiting area while awaiting definitive treatment

11. Baby C was allocated an ATS category of four, which was for an intended medical review within 60 minutes. However, due to the Emergency Department being at capacity, he was

[20] Lack of access to paediatric Emergency Department cubicles due to paediatric patients not being transferred to an inpatient ward as the children's ward did not have available beds.

not reviewed within the allocated timeframe. Baby C was only re-assessed when Mrs P re-presented to the triage desk at 9.59am to communicate her increased concerns, which was one hour and 38 minutes after his initial assessment, and nearly 40 minutes beyond the recommended timeframe for his triage category.

12. Baby C was not re-assessed by the triage nurse within the hour timeframe to determine whether his condition had improved or worsened. A change in condition may have altered the assigned ATS category, therefore changing the urgency for care.

13. A failure to perform a timely and adequate assessment of Baby C increased the likelihood a change in his clinical condition was not recognised. The internal review conducted by Sunshine Hospital identified there was a failure to perform a timely and adequate assessment of Baby C.

14. According to Associate Professor Krieser, following the death of Baby C and the internal hospital review, the hospital introduced a 24-hour nurse position to review patients in the triage waiting area. This position's primary role is to re-triage patients in the waiting area who have been waiting longer to be treated than the timeframe associated with the relevant triage category that was initially allocated to them to identify any significant clinical deterioration which would require a higher acuity triage category.

15. This is an appropriate initiative to address the issues raised above to prevent future recurrences.

Lack of consumer awareness regarding escalation pathways

16. Sunshine Hospital has a 'Call for Help' program,[21] which encourages patients and their carers to escalate their concerns when they are worried about deterioration of a patient. This program was in place at Sunshine Hospital when Baby C presented to Emergency Department. However, it appears that neither Mr P nor Mrs P were aware of this escalation pathway to voice their concerns.

17. Following the internal review, Sunshine Hospital has taken steps to increase patient and carer awareness of this program with an increase in dissemination of informational video, posters, and brochures to inform patients and their carers on arrival to the Emergency

[21] Western Health, 'Call for Help' (Web Page, 4 November 2019) <http://www.westernhealth.org.au/PatientsandVisitors/Pages/Call_For_Help.aspx>

Department. Triage staff are also tasked with consistently making patients, carers, and families aware of the 'Call for Help' program. Public health information about deterioration is also displayed in the emergency department waiting room with the information provided in English and other common non-English languages.

18. These are appropriate steps to increase consumer awareness to prevent future recurrences.

Conclusion

19. Baby C was a five-month-old infant who died at Sunshine Hospital due to myocarditis. He was taken to Sunshine Hospital Emergency Department for medical review. His initial assessment was suboptimal as a complete set of vital signs was not obtained. This may have influenced initial clinical decision-making with regards to his urgency of care. For this reason, I will make a recommendation to ensure all paediatric patients who present to Sunshine Hospital Emergency Department have a full triage assessment performed as per the standards set out by the ETEK guide.

20. However, I am not satisfied that Baby C's death would have been prevented had he received medical care more promptly. It is evident that he deteriorated quickly, and I note that there is no specific treatment for myocarditis except for supportive care, which Baby C did receive (including fluids, blood pressure support, antibiotics, and close monitoring). The cause of myocarditis is a virus for which there are no specific antiviral medications.

Recommendations

Pursuant to section 72(2) of the Act, I make the following recommendation connected with Baby C's death:

1. I recommend that Sunshine Hospital implement a policy to ensure all patients who present to the Paediatric Emergency Department have a full triage assessment performed as per the standards set out by the ETEK guide by a triage nurse. Such an assessment should include obtaining a brief history of presenting complaint and a complete set of vital signs observations taken, which comprises of heart rate, respiratory rate, temperature, blood oxygen level, and blood pressure measurements. If an initial attempt to obtain a complete triage assessment is unsuccessful, triage staff should be required to attempt to obtain the

remainder measurements while the patient is in the waiting room within an appropriate timeframe, which can be determined by the Emergency Department staff at Sunshine Hospital.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

I convey my sincere condolences to Baby C's family for their tragic loss.

I direct that a copy of this finding be provided to the following:

Mr & Mrs P, Senior Next of Kin
Western Health (care of Lander & Rogers Lawyers)
Royal Children's Hospital (PIPER Department)
Australian Health Practitioner Regulation Agency
Safer Care Victoria
Council on Obstetric and Paediatric Mortality and Morbidity (COPMM)
Australasian College for Emergency Medicine (ACEM)
Australian College of Emergency Nursing
Royal Australasian College of Physicians (Paediatric)
Detective Senior Constable Kane Treloar, Coroner's Investigator, Victoria Police

Signature:

Caitlin English
Deputy State Coroner
Date: 13 October 2020