IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 6080

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Amended pursuant to section 76 of the Coroners Act 2008 on 20 August 2021[1]

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	NB
Delivered on:	4 August 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	26, 27 August & 16 December 2020[2]
Assistant to the Coroner:	Leading Senior Constable King Taylor
Counsel for Department of Families, Fairness and Housing	E Gardner Instructed by Legal Services Branch, Department of Families, Fairness and Housing

[1] This document is an amended version of the Inquest Finding into NB's death dated 4 August 2021. The deceased's name has been replaced by a pseudonym and identifying details as to the notifier of child protection concerns at paragraph 81 has been removed pursuant to section 76 of the *Coroners Act 2008* (Vic).

[2] This inquest proceeded as a WebEx hearing in accordance with the Coroners Court of Victoria Practice Direction 4/2020 in response to the COVID-19 pandemic. All Counsel and witnesses, save for the Coroner's Assistant, appeared via WebEx. Final submissions and submissions in reply were submitted in electronic format by 25 March 2021.

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BACKGROUND AND CHRONOLOGY

1. NB was born on 16 October 2015 and died on 23 December 2016 at the age of 14 months.

2. NB and his twin brother, NJ, were born extremely premature at 26 weeks gestation and had significant medical needs. They both had a long hospital admission associated with their birth prematurity.

3. On 17 December 2015, NB had a tracheostomy inserted to maintain his airway due to subglottis stenosis. He had chronic lung disease and required oxygen delivered through his tracheostomy tube.

4. NJ was discharged home to his parents on 22 February 2016 with no further medical assistance required.

5. NB remained in Royal Children's Hospital (**RCH**) Intensive Care Unit until six months of age. He was transferred to the medical ward on 1 April 2016.

6. Shortly after this NB was medically fit to be discharged but remained in hospital as a social admission owing to protective concerns.

7. On 12 July 2016, an interim accommodation order was made by the Children's Court. NB was discharged to the care of his parents on condition they attend the Twedle Residential Stay unit.

8. On 21 July 2016 the family was discharged from Twedle and NB was removed by the Department of Health and Human Services (**DHHS**) (now known as the Department of Families, Fairness and Housing) to an undisclosed location.

9. On 22 July 2016, the Children's Court placed NB on an interim accommodation order to the RCH where he was re-admitted, and NJ was placed on an interim accommodation order to his parents.

10. On 3 August 2016, the Children's Court placed NB on an interim accommodation order for out of home care. On 9 August 2016, he was discharged from the RCH into the care of Leonie Patterson, a foster carer with Westcare Foster Care. DHHS funded nurses provided by the nursing agency Colbrow Homecare to support Mrs Patterson with NB's overnight care between 8.00pm and 8.00am in the home.

11. On 17 December 2016, Delia Jarina was the nurse on the overnight shift. Ms Jarina knew NB well and had cared for him on 13 previous occasions.

12. Ms Jarina fed him at midnight via his percutaneous endoscopic gastrostomy (**PEG**) tube, which took about one hour. At approximately 1.20am she heard NB gasp and thought he was having a seizure. Ms Jarina picked NB up and gave him five firm pats on the back to clear his chest and stimulate his breathing. She called for Mrs Patterson, then placed him on the floor and commenced cardiopulmonary resuscitation (**CPR**) and mouth to mouth resuscitation. Mrs Patterson called 000 and paramedics arrived at 1.29am.

13. Paramedics took over and the Mobile Intensive Care Ambulance (**MICA**) arrived at 1.41am. They took over resuscitation and transported NB to the RCH, arriving at 3.03am.

14. An initial computed tomography (**CT**) brain scan showed NB had a severe hypoxic brain injury which was incompatible with life. After discussions with his family and treating team, treatment was withdrawn, and NB died on 23 December 2016 shortly after the withdrawal of intensive care support.

CORONIAL INVESTIGATION

15. NB's death was reported to the coroner as his death appeared to be unexpected and unnatural and therefore was within the definition of a reportable death pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**). Further, NB's death was also reportable as he was subject to an order placing him in out of home care pursuant to an Interim Accommodation Order, meaning he was 'in care' as defined in the Act.

16. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[4]

17. The broader purpose of coronial investigations is to contribute to the reduction in the number of preventable deaths, both through the investigation findings and the making of comments and recommendations by coroners.

[3] Section 89(4) *Coroners Act 2008* (Vic).
[4] Preamble and section 67 *Coroners Act 2008* (Vic).

18. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[6] or to determine disciplinary matters.

19. The coronial investigation in this case was undertaken by a member of Victoria Police who was appointed as the coroner's investigator, Leading Senior Constable Melanie Milne.

20. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[7] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[8] 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 that they caused or contributed to the death.

21. Coroner Rosemary Carlin was the original coroner investigating NB's death. When Coroner Carlin was appointed to the County Court, I took over this carriage of the investigation in December 2019.

MANDATORY INQUEST

22. As NB was 'in care' at the time of his death, an Inquest is mandated by section 57(2) of the Act.

23. The scope of the inquest considered:

    (a) What happened on the evening of 17 December 2016 and early hours of 18 December 2016 when NB had a medical emergency and what steps were taken by Ms Jarina and Mrs Patterson regarding NB's airway management?

    (b) Who was responsible to ensure adequate training for nursing staff caring for a baby, who was subject to an Interim Accommodation Order, with a tracheostomy at home?

    (c) Who was responsible to ascertain the capacity of staff to assess and manage an evolving tracheostomy emergency in the home environment?

24. The inquest ran for three days and heard from five witnesses.

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[5] *Keown v Khan* (1999) 1 VR 69.
[6] Section 69(1) *Coroners Act 2008* (Vic).
[7] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[8] (1938) 60 CLR 336.

IDENTITY PURSUANT TO SECTION 67(1)(a) OF THE ACT

25. On 28 December 2016, NB's mother visually identified her son, NB, born 16 October 2015.

26. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

27. On 28 December 2016, Dr Sarah Parsons, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination and provided a written report, dated 2 May 2017. In that report, Dr Parsons concluded that a reasonable cause of death was "*Global cerebral ischaemia in an infant with upper airway obstruction*".

28. Toxicological analysis identified the presence of a number of medications prescribed in hospital.

29. I accept Dr Parsons' opinion as to cause of death.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

30. NB was placed in foster care with foster carer Leonie Patterson. Mrs Patterson had been a foster carer for 34 years and was an accredited foster parent with Westcare Foster Care, Melton. Mrs Patterson had experience caring for children with tracheostomy and PEG feeds. Prior to commencing as foster parent for NB, Mrs Patterson was trained in tracheostomy care and emergency management at the RCH. This training was comprehensive and involved her observing nursing staff, and then three days of in-hospital care where Mrs Patterson was observed providing total care for NB.

31. Due to NB's 24-hour care needs, DHHS Child Protection funded nursing staff provided by private nursing agency Colbrow Homecare to support Mrs Patterson overnight between 8.00pm and 8.00am with nurses in the home. Of the eight nursing agencies originally approached by DHHS, Colbrow was the only nursing agency to positively respond. Whilst DHHS originally indicated RCH would provide training for the nurses, this did not eventuate and Colbrow arranged for in-house training in infant tracheostomy care for its nurses.

Events of 17 – 18 December 2016

32. On Sunday 17 December 2016 at 8.00pm, Ms Jarina arrived as the overnight nurse for NB. NB slept between 8.00pm and 10.00pm. She stated she checked his observations at about 10.00pm.

As NB had a persistent hacking cough, she suctioned him several times before he went to sleep and approximately four times after he was asleep.[9]

33. At midnight Ms Jarina started running a PEG feed which took approximately one hour to complete. Ms Jarina stated:

'*At approximately 1.15-1.20am I heard NB gasp. I stood up ready to suction him again but when I looked down at him, his back was arched his was (sic) head back and his arms and legs were stiff. NB appeared to be suffering a seizure.*

I picked NB up from the cot and gave him 5 firm pats on the back in an attempt to clear his chest and stimulate his breathing. At the same time I yelled out for Leonie (who I presumed to be asleep) to come and help.

NB was turning a blue-ish colour. I immediately placed NB on the floor and commenced CPR. I was continuing to yell for Leonie to come to assist me.'[10]

34. In her first statement, Ms Jarina stated during one of her earlier shifts Mrs Patterson had told her that NB had suffered a couple of seizures during the day, and to keep an eye on him.[11] Mrs Patterson denied NB had suffered from seizures and stated if he had, she would have '*had him straight back to RCH to find out why.*'[12] Prior to 17 December 2016, Ms Jarina had not witnessed NB having any seizures.

35. NB was noted to be turning blue. Ms Jarina placed him on the floor and commenced CPR in the form of chest compressions.

36. Ms Jarina described NB during the 'seizure' as ''*pushing*,' … *you know when you go to the toilet,*'[13] she squeezed his shoulder, gave him five pats on the back, when his face '*started to turn blue so I put straightaway, I put him on the floor … increased oxygen and started CPR while screaming for Leonie*.'[14]

37. Ms Jarina stated NB was still connected to the oxygen through his tracheostomy. She was concerned he was not getting oxygen and stated, '*That's why I increased the amount of oxygen*

[9] Coronial Brief (**CB**) 90; Exhibit 3.
[10] CB 90.
[11] CB 90-1.
[12] Transcript (**T**) 30.
[13] T 73.
[14] T 73-4.

to maximum. The dial, I increased the dial- ... to maximise and then start CPR.'[15] She stated she covered the tracheostomy with her right thumb whilst she gave NB mouth to mouth CPR.[16]

38. With respect to whether NB's tracheostomy was blocked, Ms Jarina's second statement stated it was not blocked as NB would have coughed or struggled for breath.[17] In evidence Ms Jarina stated she did not think to determine whether the tracheostomy was blocked, by suctioning and then potentially removing it, prior to commencing CPR, '*No, was not thinking ... I was worried about him turning blue*.'[18] She believed NB was having a seizure, because he did not cough, '*What went straightaway into my mind that NB was having seizures, so it was not the case that the tracheostomy was block* (sic)'.[19] She agreed she did not check if it was blocked, she conceded she should have suctioned NB, and stated, ' … *'cause in my mind I was – have to call Leonie … and hoping that she can help me.'*[20]

39. Sometime after going to bed Mrs Patterson stated she was woken up by what sounded like a *'strangled squeal.'*[21] When she arrived at NB's room she described Ms Jarina '*kneeling on the floor, with NB over her right arm, face down and on his tummy*.'[22] She confirmed this in her evidence and disagreed when it was put that Ms Jarina was holding NB facing towards her with one arm supporting his neck and the lower part of his head, and the other hand supporting his bottom.[23]

40. Mrs Patterson stated Ms Jarina said to her, '*Leonie, he's stopped breathing*.' Ms Jarina told Mrs Patterson she had heard what sounded like a cough, but it was not a cough, and went over to suction NB but he was not breathing. Mrs Patterson stated, '*From what she said in my mind's eye he stopped breathing in the cot*.'[24] In evidence Mrs Patterson explained when she heard that he was not breathing, she '… *imagined he was dead in his cot because he was this yellow colour with dark blue lips, by the time I got to him.*'[25]

41. After retrieving her phone, Mrs Patterson immediately called 000. When she went back to NB's room, Ms Jarina had laid him on the floor and had started CPR. Following instructions from

[15] T 74.
[16] T 74-5.
[17] CB 93.
[18] T 76.
[19] T 78.
[20] T 78-9.
[21] CB 73.
[22] CB 73.
[23] T 47.
[24] CB 74.
[25] T 34.

the 000 call, Mrs Patterson put her arm under NB's neck, whilst Ms Jarina continued CPR, to bring NB's head up, and he regurgitated his milk. As he was still not breathing CPR continued.

Position of tracheostomy tube

42. When ambulance staff arrived, they noted his tracheostomy was dislodged. Mrs Patterson was not sure and had not noticed when that happened but believed it may have occurred when NB was sat up and regurgitated the milk. Mrs Patterson's statement and evidence was that NB's tracheostomy was still in place. In cross examination she clarified as the tracheostomy is tied to NB's neck, it remains physically in place, there is a curved tube that goes into the oesophagus and the only way to tell if that is displaced or blocked is to suction it, as the suction goes down and will show if the tracheostomy is out of position.[26]

43. In her second statement, Ms Jarina noted NB's tracheostomy tube was not dislodged. She recalled it was in the correct position.[27]

Suctioning

44. Mrs Patterson stated she did not assess NB's airway at the time of his arrest or during the resuscitation. She did not suction NB as she believed Ms Jarina may have already done so. She clarified in evidence she did not know whether or not Ms Jarina had suctioned NB because Ms Jarina had said to her, *'He made a cough, it wasn't a cough, I went over to suction him and he wasn't breathing*.'[28]

45. Mrs Patterson explained she did not check NB's tracheostomy to see whether he needed suctioning because, '*No, he was yellow and dead and dark blue around the lips. I was half-asleep, when she said he wasn't breathing, my first thought when he was that colour, was to call 000.*'[29] Mrs Patterson knew that with a tracheostomy, if someone was not breathing, the procedure to follow was to suction and change the tracheostomy.

46. Mrs Patterson's evidence was that she saw NB in Ms Jarina's arms she believed he was dead and '*he was gone*.' She was of the view he had not *just* passed, '*he was gone*.'[30] Ms Jarina was saying '*he's not breathing*' and it was on that basis she called 000 for an ambulance. When

[26] T 50-1.
[27] CB 93.
[28] T 35.
[29] T 35.
[30] T 36.

Ms Jarina stated she went to suction NB, but he was not breathing, '*That's when I believed he was dead in the cot*.'[31]

Subsequent texts between Mrs Patterson and Ms Jarina

47. On 20 December 2016, whilst NB was still in hospital, Mrs Patterson sent a text message to Ms Jarina updating her about NB's condition. Ms Jarina responded with the following description of events:

'*Thanks Leonie, me too, I'm still feeling upset and confused as to what went wrong. It was so sudden. I thought at first that he was going to cough like he used to. But when I saw him moving his head up and looking at his face like he is pushing it was the time I realised that something not right. Quickly I pick him up and tap his back with 5 blows.*

And screaming your name for help. He continued to hold his head up high and looked like he was still holding his breath that's the time I put him on the floor and started CPR while I was screaming your name for help. And that's the situation you saw us when you woke up after few of my screams. I have no time to ring or run to you to wake you up. Thanks for your help. I felt helpless. I still kept on thinking to what should I have done differently to revive him. Should I have suction him? Maybe he aspirated. Or maybe vent his PEG to relieve his tummy instead of starting CPR? It was so sudden that only CPR is the thing in my mind. Thanks for the ambulance as well without them he was gone. I still cry when I'm alone. We love him so much. We tried to protect him from any possible harm. But I don't know what went wrong. Did he wake up? Hope to see you soon. Take care.'

48. It was only when Mrs Patterson received this text from Ms Jarina that she stated she realised from the description that NB was still trying to breathe in his cot, '*that he was moving his head up and he was pushing and that meant that he wasn't able to breathe, he wasn't getting any air. So that should have automatically been suction and trachy change.*'[32]

Mrs Patterson's training

49. Mrs Patterson was trained at the RCH in tracheotomy care which comprised of three or four days in the Sugar glider ward with NB and a weekend of 24-hour intensive training[33] to ensure

[31] T 48.
[32] CB 38.
[33] CB 68

she knew everything she needed to know, including what to do if there was an emergency and NB stopped breathing:

'*… you would suction to make sure that there wasn't a blockage and then if the suction tube did not go down, … then you would immediately do a trachy change which when you are able to do it, it only takes about 30 seconds …*'[34]

50. Mrs Patterson changed NB's tracheostomy on a daily basis every time he had a bath and followed the same procedure each time. She explained that after changing the tracheostomy tube a number of times, as she was doing it daily, '*it takes probably about 30 seconds*.'[35]

51. Mrs Paterson attended a meeting at the RCH shortly before she brought NB home where it was discussed that all the night nurses would be trained in tracheostomy management, '*when I left the meeting, my understanding was that the hospital and DHS would source an agency with trachy nurses and that had really nothing to do with me.*'[36]

52. Mrs Patterson understood that the night nurses would be trained in tracheostomy management, she stated: '*There was no point sending someone who couldn't change a trachy. If he … was suctioned overnight and there was a blockage … the trachy would have to be changed. There was no point sending anyone who couldn't do that … There was no way I would have allowed a nurse to look after NB if she didn't have the training, … if I was aware she didn't have the training. So when these nurses came to my door, my understanding was DHS and RCH had approved these nurses and they were trachy trained*.'[37]

53. Mrs Patterson was also not aware of the arrangement that Tracey Marr from Colbrow trained the nurses at her house in tracheostomy care when they came on shift. In Mrs Patterson's view it was not possible to complete tracheostomy training in a three-hour shift handover:[38]

'Now I do understand they are nurses and they've got more nursing ability than I have, but you – I don't honestly believe you can cover all the trachy issues in three hours.'[39]

54. Mrs Patterson stated none of the night nurses had to change NB's tracheostomy overnight.

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[34] T 21.
[35] T 28.
[36] T 23.
[37] T 24.
[38] T 58.
[39] T 59.

'*So once again, I had no idea – I assumed they all could, but I had no idea who could or couldn't. But there'd never been a reason in the time I had NB for anyone to change the trachy bar myself when he had his bath*.'[40]

Ms Jarina's nursing experience and training

55. Ms Jarina qualified as a nurse in New Zealand and moved to Australia in 2009. She commenced agency nursing work and in 2014 she was employed by Colbrow Homecare. She had experience working in multiple hospitals, including the RCH and Royal Women's Hospital and had experience working with infants in neonatal intensive care and special care nurseries.

56. Ms Jarina stated she expressed an interest to provide care for NB on the basis that training from RCH would be provided, and the role of night nurse was to 'support' the full-time carer.[41]

57. Ms Jarina had nursed NB on 14 occasions. In her first statement she noted, she *'... was provided with refresher training in respect of tracheostomy management ... Nothing about the nursing required for NB was outside my experience or expertise*.'[42]

58. In her second statement she stated she was originally told she would receive training from the RCH. '*I was also told by Colbrow that NB was stable and that a carer, who had full training, would always be present and would take over from me if something happened. On this basis, I agreed to care for NB*.'[43]

59. A few weeks later Ms Jarina was told to attend NB's house for training from the nurse on night duty who had Intensive Care Unit training. The training provided for Ms Jarina was for three hours '*at NB's home by the nurse on night duty caring for NB ... The training was run as an orientation of how to care for NB but did not cover emergency tracheostomy management or how to replace a tracheostomy tube.*'[44]

60. Ms Jarina stated: '*But they said to me it's okay because Leonie has the full training and ... we were only there to takeover at night so that Leonie can have a rest.*'[45] She stated the orientation included basic care for NB, such as how to suction, feeding with the PEG and what formula to use, how much oxygen. The next night, when she attended to care for NB, she read the folder of materials from RCH. She stated she felt comfortable on the first night with the training, and

[40] T 28.
[41] T 91.
[42] CB 88.
[43] CB 94.
[44] CB 94.
[45] T 65.

in the knowledge that Mrs Patterson was around. Ms Jarina denied Ms Marr's training included instructions explaining basic life support for a tracheostomy patient. Ms Jarina stated she was never shown how to change NB's tracheostomy. When asked whether she had emergency training in relation to NB's tracheostomy, for example if he stopped breathing, Ms Jarina stated, '*I have to call Leonie, that's the thing in my mind. Leonie's got the full training – I have to do my basic life support, that's all – training*.'[46] She stated did not receive training from Ms Maher about what to do when someone with a tracheostomy is not breathing. [47]

61. In cross examination Ms Jarina confirmed she read the material from the RCH *'A training manual, basic life support for children with a tracheostomy.'* She stated, '*But back in my mind this is for me to support Leonie*.'[48] She explained that reading the RCH training manual, she was of the view that if an emergency arose, '*in my mind I'm confident that Leonie can do that if things happen … What I believe I can assist Leonie, cause that what I was promised. That Leonie can take over if anything happens, that's why I was confident to stay there and to help Leonie*.'[49]

Assessment of emergency tracheostomy management

62. The relevant guideline for emergency tracheostomy management in place at the time of NB's death was produced by the RCH. The 'Clinical Guidelines (Nursing): Tracheostomy management (the guideline) was produced in March 2008 and reviewed in May 2014.

63. With respect to emergency management, the guideline states:

> *'The majority of children with a tracheostomy are dependent on the tube as their primary airway. Cardiorespiratory arrest most commonly results from tracheostomy obstructions or accidental dislodgement of the tracheostomy tube from the airway. Obstruction may be due to thick secretions, mucous plug, blood clot, foreign body, or kinking or dislodgement of the tube.*
>
> *Early warning signs of obstruction include tachypnoea, increased work of breathing, abnormal breath sounds, tachycardia and a decrease in SpO2 levels. Cyanosis, bradycardia and apnoea are late signs – do not wait for these to develop before intervening*.'[50]

[46] T 70.
[47] T 73.
[48] T 102.
[49] T 104.
[50] CB 274.

64. The guideline states to firstly assess the airway by a process described as *'look, listen, feel.'* It instructs if the airway is obstructed, suction the tracheostomy tube, change the patient's inner cannula tube if one is present and extend the patient's neck slightly with a small towel rolled under the shoulders. If the tracheostomy tube is still blocked or dislodged, remove and re-insert a new tube.

65. It appears from the evidence NB had early signs of tracheostomy obstruction that was not assessed and recognised. Ms Jarina heard NB gasp and thought he was suffering from a seizure. In evidence she described him as 'pushing' and in her text message to Mrs Patterson she described NB as '*moving his head up and looking at his face like he is pushing'.* It is likely NB's stiffening, abnormal posturing and gasp indicated airway obstruction and emergency airway management should have occurred at this point.

66. Ms Jarina's evidence was she did not assess NB's airway. She did not appear to recognise NB turning blue, cyanosis, and apnoea, cessation of breathing, as a sign of obstruction and did not assess NB's tracheostomy tube.

67. Once an obstruction is identified the next step in the guideline is to suction the tracheostomy tube. Ms Jarina stated in her text to Mrs Patterson, '*should I have suction[ed] him?*' .

68. In her evidence Ms Jarina conceded she did not think to determine whether the tracheostomy was blocked and that she should have suctioned NB. She provided CPR instead of suctioning. She turned the oxygen on to full, rather than checking the tracheostomy for blockage. When asked why she did not suction him she stated, '*she did not think* …' which suggests to me she panicked.

69. Instead of assessing for tracheostomy obstruction Ms Jarina turned NB face down and delivered five '*firm pats on the back*.' The is no reference in the guideline under emergency management which refers to back pats. Ms Jarina's actions were not in compliance with the guideline.

70. Ms Jarina started CPR through the mouth. It is not clear whether NB received effective ventilation as he was dependent on his tracheostomy tube to breath and Ms Jarina did not mention providing ventilation through the tracheostomy. Chest compressions commenced without ensuring the patient's airway is patent are likely to be ineffective in the setting of oxygen deprivation.

71. Mrs Patterson did not assess NB's airway during NB's arrest or suction him. She stated when Ms Jarina told her NB was not breathing, she ran to get her phone and call 000. She presumed Ms Jarina had suctioned NB.[51]

72. It was not until paramedics arrived that NB was suctioned and had his tracheostomy tube replaced, which was 21 minutes after the call to 000.

73. NB suffered a prolonged period of ineffective ventilation and hence inadequate oxygenation and this directly contributed to his severe brain injury.

74. NB had a tracheostomy kit in his bedroom, which included spare tracheostomy tubes, tape and other emergency equipment. The emergency equipment was not utilised during NB's arrest.

Conclusion

75. At the time of NB's arrest, the appropriate emergency management was not initiated. There was a lack of adherence with best practice guidelines from the RCH. The key concept of tracheostomy management and basic life support is to prioritise opening the airway and ensure patency of the airway. There was no assessment of the tracheostomy or airway patency, no recognition of tracheostomy obstruction, a lack of suctioning and basic emergency tracheostomy management such as re-inserting a new tracheostomy tube. NB was incorrectly and inappropriately positioned, and he received inappropriate back pats and ineffective ventilation.

76. Based on Ms Jarina's past work experience and the recent refresher training in tracheostomy management, it appeared Ms Jarina had the experience to care for NB. She did not follow the basic steps outlined in the guidelines for a tracheotomy emergency, despite her experience and training, she was not competent in the basic life support required for emergency tracheostomy management.

77. In my view it is untenable for Ms Jarina, as the registered nurse on night shift, to deflect emergency care responsibility to Mrs Patterson. Ms Jarina accepted NB was her patient and she was being paid as a registered nurse to care for NB. Ms Jarina acknowledged in her second statement that, *'... it is my responsibility to ensure that I have the appropriate training,*

[51] CB 82-83.

experience and skills to care for my patients. I will never again care for a patient without having the appropriate training and skills, irrespective of the request of my employer or agency.'[52]

78. The evidence was inconclusive as to when NB's tracheostomy was dislodged and the cause his arrest is unknown. The evidence however supports a finding that there were deficiencies in the acute management of NB's respiratory arrest on 18 December 2016, and as Ms Jarina was not competent in emergency tracheostomy management this precluded an opportunity to avoid NB's fatal outcome.

79. Ms Jarina has taken steps to rectify gaps in her tracheostomy education and training by attending an emergency tracheostomy management course.

Discharge planning for NB

80. As NB was on an interim accommodation order at the time of his death, his parents remained his legal guardians and DHHS, through the foster care placement, was responsible for his day to day care. As NB was discharged from RCH into the care of Mrs Patterson, DHHS was responsible for planning his safe discharge and DHHS had responsibility for his overall care whilst he was placed with Mrs Patterson.

81. Alison Norbury, a principal practitioner from DHHS Child Protection, became involved with NB's case on 6 July 2016, following concerns[53] that, *'that NB remained in hospital despite being medically fit to be discharged*.'[54] He remained in hospital as a *social admission* due to protective concerns concerning NB's parents' ability to manage his complicated care needs in their home.[55]

82. On 12 July 2016, NB was placed on an Interim Accommodation Order to his parents on condition they reside at Twedle.[56] On discharge on 21 July 2016, NB was placed on further interim accommodation order to the RCH.

83. From 22 July 2016, Ms Norbury participated in numerous multidisciplinary meetings at the RCH for NB. Discharge planning meetings involved discussions about NB, and the RCH provided the input regarding NB's medical care needs.[57]

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[52] CB 95.
[53] Notifier of concerns removed pursuant to section 76 of the *Coroners Act 2008* (Vic).
[54] T 244.
[55] T 245.
[56] The Twedle Residential Program provides early intervention and prevention programs for parents.
[57] T 308.

84. Assisting with foster care placement, Westcare identified Ms Patterson as a potential foster carer. From 22 July 2016, once Mrs Patterson had been identified as a suitable foster carer, further planning was undertaken to implement support for Mrs Patterson as, '*NB required 24 hour care and as she was a single carer the placement would not have been sustainable without the provision of overnight support seven nights per week.*'[58]

85. On 26 July 2016 at a discharge planning meeting, it was agreed that overnight nurses for NB would be the most appropriate support for him.[59] In her statement Ms Norbury stated:

'*The issue of overnight support for NB was canvassed. The most suitable option agreed to by the professional care team was for DHHS to purchase the services of suitably qualified staff via a nursing agency.*'[60]

86. Notes of the discharge planning meeting by the RCH note, that DHHS Child Protection '… *aim to support ... carer in the home environment with nursing staff.*'[61] Notes of the discharge planning meeting by DHHS state: '*CP advised there is difficulty locating paediatric trachea trained nurses for NB's release.*'[62] DHHS stated the decision to hire overnight nurses was a joint decision '*agreed to by the professional care team*', whereas the RCH suggested it was a decision by DHHS.[63]

87. As of 26 July 2016, DHHS had started making inquiries with nursing agencies about whether they could support NB's placement.

88. At a discharge planning meeting on 1 August 2016, overnight nursing support for Mrs Patterson was discussed, and Ms Norbury noted,

'*The option of asking the nursing agencies, whether they have nurses that would be prepared to train was put forward by Royal Children's Hospital and we agreed to make enquiries. It wasn't explicitly discussed who was going to provide that training.*'[64]

89. Ms Norbury however was of the understanding that the RCH would be able to provide training for agency nurses. '*The option of asking if nurses would be trained was put forward on 1 August, at that meeting.*'[65] She explained there were many conversations with the RCH about

[58] Exhibit 11, p 3.
[59] T 307.
[60] Exhibit 11, p 3.
[61] Exhibit 14.
[62] Exhibit 11, AN1.
[63] CB 201-2.
[64] T 275.
[65] T 283.

training which related variously to NB's carer, his parents and the Family Choices workers. When she was asked by the RCH,

'… *whether we could approach nursing agencies and asked if they had nurses who would be prepared to be trained to care for NB. And my take away from that meeting was that they would train them. I actually didn't seek clarity at that point … But my takeaway was, when the RCH suggested that nurses may be - could be trained, because they were going to train them*.'[66]

90. On 2 August 2016, Ms Norbury sent an email to a variety of agencies,[67] including Colbrow, setting out NB's medical needs regarding his tracheostomy, and seeking nursing staff who were currently trained or prepared to be trained. This was based on information provided by the RCH at the discharge planning meetings.[68]

91. Ms Norbury sought to identify a nursing agency to provide support for NB's foster care placement, however numerous agencies declined on the grounds they delivered services to hospitals rather than homes, or they did not have appropriately qualified nursing staff.

92. On 2 August 2016, after Ms Norbury had sent emails to eight nursing agencies and contacted five other nursing agencies via their websites, Ms Marianne Zarth from Colbrow responded to her email that Colbrow would be able to provide the requisite number of qualified nurses to cover all shifts. Ms Zarth indicated assistance would be required for training the nursing staff. On 2 August 2016, the RCH advised it would not be able to provide assistance with training. As a practical solution, Colbrow indicated it would develop in-house training for their registered nurses as part of its professional development program.[69]

93. Ms Georgia Hall from DHHS Child Protection was advised the RCH was not able to provide training for external nurses.[70] The RCH was also unable to provide details of an agency that would be able to provide the training. It was the agency's responsibility to provide training nurses around tracheostomy care. Ms Zarth put forward a proposal that Colbrow would provide in-house training in tracheostomy care for nurses who would be providing night shift care for NB.

94. Ms Norbury confirmed both DHHS and the RCH were aware that in-house training was proposed by Colbrow, and Ms Norbury was not aware of any concerns expressed about this

[66] T 282-3.
[67] Exhibit 11, Annexure 5.
[68] T 309.
[69] T 250.
[70] T 283-4.

proposal by the RCH. [71] As far as Ms Norbury was aware, the RCH was comfortable with that training model.

95. On 4 August 2016 there was a discharge meeting at RCH. This was attended by approximately twelve people, discussing NB's discharge and ensuring his medical needs were safely met. Ms Norbury confirmed no concerns were raised by DHHS or RCH regarding Colbrow training its nurses in-house in tracheostomy care.[72] Ms Norbury confirmed she took comfort from the fact no-one from RCH expressed any concern with the training model proposed by Colbrow. No representative from Colbrow was present at the meeting, although Mrs Patterson was present in part. Ms Norbury agreed that if Colbrow had been at the meeting, there may have been an opportunity for discussion about what was proposed regarding training for the nurses who would be looking after NB, as the focus of the meeting was on practical issues for NB's care.[73]

96. Ms Norbury stated: '*My understanding was that the agency nurses would have a professional obligation to work in accordance with their relevant nursing registration and accreditation standards*.'[74] She explained DHHS made the decision to purchase registered nurses to care for NB, as they are qualified, experienced and trained to meet the needs of their patients. They are regulated by AHPRA[75] and all have a responsibility to ensure, as a nurse, if they undertake a role caring for somebody, that they will have the skills able to meet the needs for that client: '*… as we purchased the service for a registered professional, that they would also work in accordance with their accreditation and registration*.'[76] She confirmed this meant a professional obligation to only work within their areas of competency. Ms Norbury agreed that any nurse engaged to care for a child that had medical needs, including a tracheostomy would ensure that skillset was within their competency.[77]

97. Ms Norbury stated DHHS was of the view that by organising night-time nurses to care for NB, '*we thought we were purchasing the best service available for NB*.'[78] It was a model of care chosen, with the imprimatur of the RCH and was more costly than the Family Choices Model run by the RCH.

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[71] T 310-11.
[72] T 312.
[73] T 314.
[74] T 249, Exhibit 11, Statement of Alison Norbury, p 5.
[75] Australian Health Practitioner Regulation Agency.
[76] T 315.
[77] T 316.
[78] T 328-9.

98. Ms Norbury had a similar expectation of the nursing agency that necessary checks would be conducted to ensure the nurses had the necessary professional qualifications, experience, skills and training to meet a child's needs. She agreed whilst the agency identifies the appropriately qualified nurses, it is the nurses' responsibility to form a view about their own competency.[79] Ms Norbury stated:

'*The nurse is the person that's responsible for understanding their scope of their … nursing capacity, so their skills, and from the agency we'd expect that there's been some … referencing and checking in respect of that.*'[80]

99. Ms Norbury stated DHHS did not ask Colbrow to provide the program of training to be delivered, '… *given we were informed that nursing agencies are responsible for in-house training … when the agency said that they could provide training, we are relying upon that.*'[81] The RCH advice was that the nursing agency was responsible for handling training.[82] Ms Norbury indicated DHHS accepted this because RCH were the medical professionals.[83] The RCH was aware of the plan for the training to be in-house, and raised no concerns. DHHS was aware the training would be several hours,[84] hands on, with NB present and would include all aspects of tracheostomy care.[85]

100. DHHS requested RCH provide any necessary information about NB to Colbrow to assist the nursing staff in caring for NB. RCH indicated NB would be discharged with a folder outlining his care needs, including tracheostomy care, to be kept with NB.

Conclusion

101. I am satisfied from the evidence that DHHS Child Protection took adequate steps to ensure appropriate foster care and nursing staff were chosen to care for NB.

102. Mrs Patterson was selected by Westcare for her considerable experience, and underwent significant training provided by the RCH in relation to tracheostomy care and NB's medical needs.

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[79] T 316.
[80] T 317.
[81] T 289.
[82] T 289.
[83] T 290.
[84] T 295.
[85] T 293.

103. DHHS Child Protection contacted numerous nursing agencies prior to Colbrow confirming it was able to provide nurses. Colbrow was the only nursing agency that had nurses trained in infant tracheostomy care and the agency had a number of nurses who regularly worked at the RCH. After RCH confirmed it was not able to provide training, Colbrow indicated it could provide in-house training.

104. I am satisfied DHHS with advice from the RCH arrived at a reasonable model of care for NB. The choice of Mrs Patterson based on her experience was appropriate as was the training in tracheostomy care provided to her by the RCH. The decision to use night shift nurses to support Mrs Patterson also appears appropriate. This model of care was approved by the RCH and DHHS kept the RCH informed about Colbrow and Colbrow's in house training proposal. I am satisfied DHHS took appropriate measures to ensure appropriate nursing staff were caring for NB.

105. DHHS was responsible for organising NB's placement in foster care. DHHS relied on medical advice from the RCH regarding NB's post discharge care needs and organised for nurses from the nursing agency Colbrow. Miscommunication occurred between the three organisations; DHHS, the RCH and Colbrow that compromised patient care.

The RCH's role in NB's discharge planning

106. The RCH was involved in NB's discharge planning and was satisfied the medical care arranged for NB was appropriate. Danielle Smith, Clinical Director of Family Youth Services, stated the RCH discharged NB into the care of DHHS and the foster care worker.[86] RCH had provided the training in tracheostomy care to the foster carer to ensure a safe environment for NB.

107. The RCH Respiratory team prepared a letter dated 1 August 2016 regarding NB's Children's Court hearing on 3 August 2016, recommending that the Children's Court make a determination about NB's placement upon discharge from the hospital, and stating:

'*NB is now medically well and able to be discharged and a foster carer has attended the RCH and is now trained and competent in his cares*.'[87]

108. The letter went on to provide a detailed summary of NB's comprehensive care needs, noting that caring for a child with a tracheostomy requires specialised training.

[86] T 153.
[87] CB 195.

109. Post discharge, NB received care coordination and support by the RCH Family Choice program, which included respite in the home provided by trained and credentialed support workers for 12 hours per week. It did not include overnight respite. '*The packages in the home have not been designed to include the provision of support by registered nurses*.'[88]

110. When the RCH was advised by DHHS that NB's foster carer required extra support at night,

'*The RCH Respiratory team provided the Children's court and Child Protection with information regarding NB's care needs and a list of required skills in order to care for NB in the home*.'[89]

111. Following NB's death the Coroners Court received a letter from Colin Robertson, Senior Physician, Respiratory Medicine, and Sarah Connolly, Manager Social Work, from the RCH dated 20 February 2017 stating,

'*We respectfully request that the Coroner's Court investigate the circumstances leading to NB's death particularly in relation to the training and competence of the agency nursing staff. We understand that the nursing care was provided by Colbrow Health Care agency, PO Box 4012, Box Hill South, Victoria 3128*.'[90]

112. A similar letter was sent to Tracey Beaton, Director and Chief Practitioner, Office of Professional Practice at DHHS requesting investigation of the circumstances leading to NB's death, '*particularly in relation to the training and competence of agency nursing staff*.' The letter concluded:

'*In future, RCH will directly ensure the competency of carers for children with tracheostomies via RCH Family Choice model. This will require appropriate resources from Child Protection services.*'[91]

113. The RCH was aware of the plan for nursing care to be provided for NB overnight and the RCH was aware DHHS Child Protection was arranging for this through a nursing agency, Colbrow. Ms Smith's experience of the RCH using agency nursing staff was that the agency has the responsibility for training the nurses to an appropriate standard.[92] She agreed DHHS would not

[88] CB 201.
[89] CB 200-1.
[90] CB 190.
[91] CB 194.
[92] T 170-1.

have the medical expertise to review or check the efficacy of the training Colbrow was organising.[93]

114. As agency nurses were organised for NB's overnight care, the RCH would not play a role in their training,[94] it was RCH's policy which precluded RCH training the agency nurses.[95] '*Our patch (was) to train the foster-care worker who was providing care for NB*.'[96]

115. In Mr Robertson and Ms Connolly's letter of concern to Tracey Beaton they stated:

'*NB had been residing in out of home care with in home nursing care provided for respite reasons. The nursing care was arranged by DHHS Child Protection staff in close consultation with the RCH treating team…Nurses with general training are not equipped to manage a tracheostomy. Indeed even within the Royal Children's Hospital there's only a small group of specialised nurses who can safely care for these children …*

… In NB's situation the relevant care agency did not provide staff who were competent in tracheostomy care – with fatal consequences.'[97]

116. When questioned about this at the inquest, Ms Smith did not believe that this information, about tracheostomy care being specialised, should have communicated to Colbrow by the RCH, as in her view it is knowledge the agency should already have.[98] Ms Smith agreed it was important that NB was cared for by nurses who were able to deal with his tracheostomy.[99] She agreed that caring for a child with a tracheostomy requires specialised training and nurses with general training are not equipped, and indeed it is an area of specialisation within the nurses at the RCH itself, and agreed this information should be been communicated by RCH to DHHS.[100]

117. Ms Smith's evidence was that adequate tracheostomy training should include: a review of the nursing clinical practice guidelines for a tracheostomy patient, and resuscitation of a tracheostomy patient, ensure staff members have done an emergency tracheostomy change and performed resuscitation for a tracheostomy patient before being signed off as competent.[101] There is a competency framework, and training would happen over a period of days, depending on the level of prior knowledge. In her opinion, three hours training would not be sufficient

[93] T 177.
[94] T 145.
[95] T 154-5.
[96] T 153.
[97] CB 192 Letter to Tracey Beaton, from Colin Roberston and Sarah Connolly dated 10 January 2017.
[98] T 159.
[99] T 160.
[100] T 160-1.
[101] T 178.

training if the nurse had no prior tracheostomy experience.[102] Ms Smith noted the crucial point to training would be the ability to do an emergency tracheostomy change on a patient, and the RCH would not deem anyone competent until they had that training.[103]

118. Ms Smith was aware DHHS requested the RCH to provide training to the Colbrow nurses. She maintained it was not the RCH's responsibility to provide the training, as the agreement for the night nurses was between DHHS and Colbrow.

Conclusion

119. It is unclear exactly why the RCH was precluded from providing training to the agency nurses employed by Colbrow. In contrast, the Family Choice Support workers were employed by agencies to provide RCH services and they were trained and credentialed under the RCH training model.[104] In NB's case, Ms Smith stated: '… *as the registered nurse was engaged directly by Child Protection, the RCH was not directly involved in her credentialing process*.'[105]

120. However given the close working relationship between DHHS and the RCH, and the numerous discharge planning meetings, I am surprised the RCH did not impress upon the DHHS the specialised nature of training required by the night nurses who would be caring for NB. Mr Robertson referenced NB's '… *nursing care was arranged by DHHS Child Protection staff in close consultation with RCH treating team.*'[106] The RCH held the medical expertise about NB's specific needs, and it is unfortunate it did not communicate in stronger terms to the DHHS the exact nature of the training that was required, given the view that, '*Nurses with general training are not equipped to manage a tracheostomy*. *Indeed even within the Royal Children's Hospital there is only a small group of specialised nurses who can safely care for these children.*'

121. Whilst the RCH had provided detailed information at a high level to the Children's Court about NB's specialised medical needs, it appears this detail was not effectively communicated at the practical discharge planning level.

122. The RCH's intense involvement in NB's medical care and discharge planning during the period of his admission is at odds with the 'hands off' approach it took to the training needs of the Colbrow nurses who were to be night carers for NB. Whilst the provision of appropriate training

[102] T 179.
[103] T 179.
[104] CB 202.
[105] CB 203.
[106] CB 189.

was the responsibility of the nursing agency, as conceded by Colbrow, I am of the view that the RCH could have been more effective in its communication about the extremely specialised nature of NB's care requirements particularly given the lack of other external training options.

123. The RCH acknowledged:

'*If external nursing staff are engaged by DHHS, it is RCH's responsibility to ensure that the child's care needs are clearly articulated but it is not RCH's responsibility to train these nurses.*'[107]

124. The inquest heard evidence that when the RCH now transitions children with complex chronic medical conditions to the home environment, the current position is to *de-medicalise* the home environment. This uses a support worker model, support workers who are trained in the patient's medical care to the same level of parents, are the only support workers endorsed and trained by the RCH,[108] '… *it's a personalised model dependent on the children's medical complexity and vulnerability to ensure they get the right training and support in the home environment*.'

125. Ms Smith confirmed overnight carers could have been provided for NB, '*it's something we could have done at the time with NB, but it was certainly not something that was overly explored*.'[109]

126. The situation now appears to have been remedied so that if extra support or respite is required above that allocated by the Complex Care Hub package (the current iteration of the Family Choice program),

'DHHS will provide the RCH with the required funding for the extra hours which will be provided through the support worker model. This removes the need for further respite care being provided by registered nurses engaged by Child Protection without RCH oversight.'[110]

127. It appears that the funding model now provided by DHHS direct to the RCH enables RCH to train and pay for extra support workers where required.

128. It was identified by the RCH critical incident review (**CIR**) process that the support workers and the foster carer were trained with the RCH respiratory education package, but the nursing

[107] CB 204.
[108] T 137, 147.
[109] T 181.
[110] CB 203.

staff engaged by DHHS Child Protection did not receive this training. Further, it identified that Child Protection did not appreciate the complexity of the patient's clinical situation, '*despite attempts by key clinical and managerial staff at the RCH to make this clear*.'[111]

129. Given the RCH was the repository of the specialised medical expertise regarding NB's needs, it should also bear responsibility for its lack of success in communicating the extent of NB's specialised needs to DHHS in its efforts to source appropriately qualified night nurses.

130. I note a recommendation from the CIR included ensuring appropriately credentialled RCH staff (inclusive of third-party arrangements) provide support to consumers in the community.

131. There was a disjointed approach to discharge planning as a result of the RCH not being involved in the training of agency nurses on account of the contractual relationship between DHHS and Colbrow. The RCH did not provide appropriate advice to DHHS as to the specialised nature of the training required by the night nurses and this was a fault line in the coordination of NB's post discharge care.

132. The RCH did not adequately discharge this responsibility and I intend to make a recommendation reinforcing the importance of the communication between agencies about health care needs in the discharge planning process.

Colbrow's role in NB's care

133. Colbrow is a nursing agency and a member of the Association of Nursing Recruitment Agencies and a member of the Recruitment, Consulting and Staffing Association.[112]

134. Marianne Zarth, Business Operations Manager for Colbrow explained their nurses self-select their shifts, based on availability and information they are given about the particular job by Colbrow.[113]

135. On 2 August 2016, Ms Zarth received an email from Alison Norbury, DHHS, seeking nurses for night shifts and outlining NB's care needs. The email was followed up with a phone call from Georgia Hall, DHHS. '*The initial advice from the Department was that training would be provided, that they were looking for nurses trained or prepared to be trained …*'.[114] Ms Zarth sent an email to all nurses listed on their data base seeking expressions of interest, outlining

[111] CB 204.
[112] T 234.
[113] T 202.
[114] T 196.

details from the email about NB's needs and that tracheostomy training by the RCH would be provided. Ms Zarth confirmed her initial conversation with Ms Jarina about the role and that training would be delivered by RCH.[115]

136. Colbrow was then advised that training would not be available from the RCH and Ms Zarth stated:

'*The RCH refused to train our nurses, because we weren't part of the Family Choice program. Colbrow offered to pay for our staff to be trained, which was again denied by RCH.*'[116]

137. In her statement Ms Zarth stated she was told by Ms Hall that:

'C&B nurses as they were not classed as family members or primary carers and, therefore, were not eligible for training under the RCH's Family Choices Program (a state-wide program to provide home-based support to families of children with high levels of complex ongoing medical care needs).'[117]

138. Ms Zarth stated to Ms Hall,

'... that C&B would pay the RCH for training if that would make a difference. Ms Hall indicated that the RCH training was not possible and that a 'work around' solution would need to be found.'[118]

139. When the DHHS confirmed RCH would not be providing training, Ms Zarth advised that Colbrow decided to use experienced nurses with paediatric experience to train the other nurses, '… *based on information that I downloaded from the RCH website on tracheostomy, basic life-support, etc ... the Department were okay with that and we proceeded in that manner.*'[119]

140. Ms Zarth identified nurse Tracey Marr to provide the training, based on her work history, qualifications, resume, reviewing her experience, she had, '… *put her hand up ... she was interested ... it matched her work history ... She'd been nursing something like 30 years in ICU ...*'.[120] Ms Zarth stated there was no communication between the RCH and Colbrow. Ms Zarth was not aware of the RCH view (as expressed in the subsequent correspondence from Mr Robertson and Ms Connolly) that nurses with general training were not equipped to manage

[115] T 208.
[116] T 197.
[117] CB 97.
[118] CB 97.
[119] T 197.
[120] T 199.

a tracheostomy patient and that only a small group of specialised nurses at the RCH were considered sufficiently qualified to be capable of caring for these patients.

141. DHHS accepted the training solution devised by Colbrow and paid for the training on an hourly basis.

142. The evidence from Ms Zarth was that Colbrow was not provided with NB's care plan or discharge documents.

143. Ms Zarth downloaded relevant manuals from the RCH website and '*I had instructed Tracey to conduct the training, based on the content of those manuals*.'[121]

144. On 9 August 2016, Ms Marr provided three hours of training to Ms Jarina prior to her commencing her shift with NB. Ms Jarina's evidence was the training comprised of Ms Maher telling her to read the RCH manuals on her own and there was no practical component, such as changing the tracheostomy, as part of the training.[122]

145. Ms Zarth denied stating or suggesting to Ms Jarina that as Mrs Patterson, the foster carer was fully trained in tracheostomy care, she would 'take over' in an emergency. Ms Zarth stated, '*No, because she's employed there as a registered nurse ... Delia may have been told that Leonie the foster-carer was there, she was trained, but there's never been any conversation that you hand over your responsibility to the carer.*'[123]

146. Ms Jarina never expressed concerns to Ms Zarth regarding her competency to care for NB or raised any issue with the adequacy of the training provided.[124] '*She never raised any concerns and continued to submit availability*.'[125]

147. Ms Zarth indicated with the benefit of hindsight Colbrow would have insisted on RCH training.

148. Ms Zarth was asked about the relationship between the responsibility of a nurse to ensure they practice within their scope of expertise and Colbrow's obligations as an agency to ensure the nurses supplied for a job a competent to the task. Ms Zarth was of the view that Colbrow does not have a role to determine a nurse's scope of practice, *'... that's part of their AHPRA*

[121] T 199.
[122] T 228.
[123] T 203.
[124] T 202-3.
[125] T 203.

registration that they work within this … we rely on their feedback to state … 'I'm not suitable for this.''[126]

149. Ms Zarth had no nursing qualifications but devised a training scheme for nurses to gain experience and expertise in tracheostomy management. She did this by downloading manuals from the RCH website and organising for Ms Maher, an experienced ICU nurse, to conduct the training. Ms Zarth had no firsthand knowledge of the training Ms Maher provided, and she did not know whether it included changing a tracheostomy or demonstrating emergency tracheostomy management.

Conclusion

150. Colbrow had responsibility for ensuring adequate staff training, including emergency tracheostomy training, for their nurses who provided care for NB.

151. Colbrow conceded that:

'*It is the responsibility of the nursing agency to ensure their staff have the experience and/or training as outlined in the scope of requirements/selection criteria from the person/organisation requesting the placement to ensure suitable experience to assess a potential emergency.*'[127]

152. I accept Ms Jarina's evidence that the training did not include changing a tracheostomy or demonstrating emergency tracheostomy management. Although I do not have direct evidence of the contents of the training, it is not inconsistent with Ms Zarth's evidence, who had no firsthand knowledge of the content, and is consistent with Mrs Patterson's evidence, who was unaware that any 'on the job training' was taking place at her home and stated that none of the night nurses ever had to change NB's tracheostomy.

153. Ms Zarth has recognised that in hindsight Colbrow '*should not have taken on NB's care program without having received the RCH's training*.'

154. All the nurses who worked with NB were experienced registered nurses with current AHPRA registration and paediatric experience.

155. The qualifications and experience of Ms Jarina indicated she was appropriately qualified for the requirements of caring for NB. However the training organised by Colbrow provided by Ms

[126] T 236-7.
[127] CB 132.

Marr did not include instruction or demonstration about changing the tracheostomy or the steps in emergency tracheostomy management. Therefore, the training did not appear to meet the standard of the training provided by the RCH to Mrs Patterson. Further, Ms Jarina did not follow the steps for tracheostomy emergency management as outlined in the RCH guidelines.

156. Colbrow noted:

'At no time did RCH or DHHS indicate that NB's care needs would require training beyond the normal training and experience that one would reasonably expect of an RN.'[128]

157. The training plan implemented by Colbrow was not of sufficient standard to train Ms Jarina adequately in emergency tracheostomy management. This relates back to the RCH's lack of effective communication to the DHHS or Colbrow about the specialist nature of the medical skill set required for NB's care.

158. There is an inherent difficulty in ensuring that nursing agency staff are adequately trained in emergency tracheostomy management. Ultimately, the individual nurse is the best gauge of their level of experience and ability in such an emergency situation.

159. Since NB's death Colbrow has advised it now has a more exacting client intake process to ensure they only accept clients for whom it can provide staff with appropriate skills and has employees with the correct skill set prior to conducting client in-take.

FINDINGS AND CONCLUSION

160. Having investigated the death, and held an inquest, I find pursuant to section 67(1) of the Act that NB, born 16 October 2015, died on 23 December 2016 at The Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria, from global cerebral ischaemia in an infant with upper airway obstruction in the circumstances described above.

161. In submissions the Royal Children's Hospital proposed recommendations, some of which relate to communication issues between the RCH and DHHS during the discharge planning process.

[128] CB 136.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. **To the Royal Children's Hospital:** Where the Royal Children's Hospital provides advice as to the healthcare needs of a child subject to Children's Court orders, that advice should be communicated in writing to the Department of Families, Fairness and Housing and recorded in the Department of Families, Fairness and Housing's CRIS system and provided in writing to those people providing for the immediate care and welfare of the child, as well as to the Children's court, the parties and their legal representatives, including where relevant, the Court appointed independent children's lawyer.

2. **To the Royal Children's Hospital, the Department of Families, Fairness and Housing and the Department of Health**: That the Royal Children's Hospital, Department of Families, Fairness and Housing, and the Department of Health consider, develop and expand models for the embedding of healthcare knowledge within Child Protection, including a wider roll out of the Vulnerable Children's Health Project.

3. **To the Royal Children's Hospital and the Department of Families, Fairness and Housing**: To review the current memorandum of understanding in place between the two organisations in light of this Finding to strengthen relationships and clarify ambiguities, particularly to ensure it reflects the importance in discharge planning to delineate each of the roles and responsibilities of care between DFF&H and RCH where a third party agency is involved in care provision. This should be sufficient to clarify, if a similar situation were to arise in the future, for example, whose responsibility it is to ensure adequate training for staff caring for a patient with a tracheostomy at home, and whose responsibility it is to ascertain the capacity of attending staff to assess and manage an evolving tracheostomy emergency in the setting of a home environment.

Pursuant to section 73(1) of the Act I direct this finding be published on the Internet.

I convey my sincere condolences to NB's family for their loss.

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

Senior Next of Kin

Ms Delia Jarina (care of Lander & Rogers)

Royal Children's Hospital (care of K&L Gates)

Colbrow Healthcare (Collins & Brown Pty Ltd) (care of Clyde & Co)

Department of Families, Fairness and Housing

Ms Liana Buchanan, Commission for Children & Young People

Leading Senior Constable Melanie Milne, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 4 August 2021