IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 006467

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Master T[1]
Date of birth:	[redacted] 2018
Date of death:	25 November 2019
Cause of death:	*Chronic Bronchial Asthma*
Place of death:	[redacted], Victoria
Keywords:	*Facsimile – communication in medical context*

1. This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased, his family members and select individuals with pseudonyms to protect their identity and redact identifying information

INTRODUCTION

1. Master T[1] was 17 months old at the time of his passing. He lived with his mother [redacted] (**Ms T**) and his grandfather [redacted] (**Mr T**) in [redacted]

2. On 25 November 2019, Master T was found unresponsive by his mother in his cot at the family home. Sadly, he was later pronounced deceased by attending paramedics.

THE CORONIAL INVESTIGATION

3. Young Master T's passing 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.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. 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.

6. Victoria Police assigned Detective Acting Sergeant [redacted] (**DS**) to be the Coroner's Investigator for the investigation of Master T's passing. The Coroner's Investigator conducted inquiries on my behalf and provided a comprehensive statement regarding the investigation which included the Investigative Checklist, *Sleep Related Sudden Unexpected Death of an Infant or Child* (**Investigative Checklist**).[2]

7. The Court obtained Master T's medical records from the Royal Children's Hospital (**RCH**), The Northern Hospital (**TNH**) and Roxburgh Park Superclinic as well as his records from the Department of Families, Fairness and Housing (DFFH referred to in this finding as **Child Protection**).

[1] Referred to in this finding as "Master T", unless more formality is required.
[2] An investigative tool developed to assist with investigations involving the sudden deaths of infants.

8. Statements were also obtained from general practitioner (**GP**), Dr Saeid Bahrami[3]; Consultant Paediatric Emergency Physician and Head of Paediatric Emergency, TNH, Dr Loren Sher[4]; Chief Legal Officer, Northern Health, Richard Laufer[5]; Nadine Stacey, Clinical Lead – Quality and Safety (Nursing and Allied Health), RCH[6] and Maria-Veronica Martin, Director, Child Protection, Hume Moreland Area within the North Division at Child Protection[7].

9. Further, as part of the coronial investigation, the Coroners Prevention Unit (**CPU**) was asked to review the appropriateness of the medical management of Master T's asthma. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners.

10. This finding draws on the totality of the coronial investigation into Master T's passing. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[8]

Background

11. Master T was born on the morning of [redacted] 2018. His mother was 22 years old and reportedly used cannabis and methamphetamine up until she was 32 weeks pregnant as she was unaware of the pregnancy until that time.

12. At [redacted] Hospital on [redacted] 2018, Master T was found to be in a breech[9] presentation and an emergency Caesarean section was booked. At 7.22am the membranes ruptured, the umbilical cord prolapsed and there was accompanying meconium[10] stained liquor.

[3] Dated 11 January 2021.
[4] Dated 14 January 2021.
[5] Dated 19 January 2021.
[6] Dated 28 June 2021.
[7] Dated 27 July 2022.
[8] 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.
[9] Breech presentation means presenting buttocks or feet first (a footling breech) instead of the usual head first. Breech deliveries are at high risk of obstruction and compression of the umbilical cord leading to fetal asphyxia
[10] Meconium is the content of the fetal bowel. It is dark green/black in colour. It the course of a normal birth it is not usually passed in utero. Its presence in the liquor is an indication of fetal distress. If meconium is aspirated into the lungs it can cause severe lung inflammation.

13. The Caesarean section subsequently became a 'crash' Caesarean[11] at 7.46am. There was no paediatrician present at the delivery. When born, Master T had a very slow heart beat and was responding poorly. He required cardiopulmonary resuscitation (**CPR**) and breathing assistance and responded to this after several minutes. His Apgar[12] scores were recorded as 2 at 1 minute, 4 at 5 minutes and 6 at 10 minutes. He weighed 3610 grams.

14. Master T was transferred by the neonatal retrieval service (**NETS/PIPER**) to neonatal intensive care unit (**NICU**) at the Mercy Hospital. During transfer Master T had respiratory distress and there was concern that he may have being fitting. Master T subsequently spent 15 days in hospital.

15. The retrieval doctor noted that Child Protection had been notified of the case. Master T's mother subsequently moved to Sydney two weeks after the birth and Child Protection arranged for his grandfather to be his primary carer. Social work notes from RCH record that Mr T had a history of mental illness with suicide attempts. There was considerable financial stress in the family, with significant rent arrears and an inability to afford medication and other expenses. Mr T had no mobile phone, his car had been impounded and he attended the Salvation Army for food packages. Master T's mother returned six months later.

16. Dr Bahrami of the Roxburgh Park Superclinic, GP, first reviewed Master T on [redacted] 2018 when Master T was brought by his grandfather for his four month immunisations. There were no concerns with his general health but a senior practice nurse provided further advice, support and assistance to Mr T given that he was caring for Master T on his own.

17. On [redacted] 2019 Master T was seen by Dr Bahrami with his grandfather and was diagnosed with an upper respiratory tract infection and antibiotics were prescribed.

18. Dr Bahrami reviewed Master T on [redacted] and [redacted] 2019 for his six month and twelve month immunisations. He noted that Master T was in good health with normal growth and no abnormalities were detected on examination.

[11] There are a number of obstetric complications in which a very rapid or "crash" Caesarean section is necessary to save the foetus from death or disability. In the case of a 'crash' section the medical team will be dealing with a true emergency situation, when the baby has to be delivered with extreme urgency.

[12] Apgar scores are clinical indicators of a baby's condition shortly after birth. The score is based on 5 characteristics of the baby: skin colour, pulse, breathing, muscle tone and reflex irritability. Each characteristic is given between 0 and 2 points, with a total score between 0 and 10 points. An Apgar score of 7 more at 5 minutes after birth indicates that the baby is adapting well to the environment, while a score of less than 7 indicates complications for the baby.

19. On 1 September 2019, Master T was taken by ambulance to the Emergency Department (**ED**) of RCH presenting with a wheeze and viral illness. He was admitted overnight and given Ventolin[13], Atrovent[14] and dexamethasone[15] with a social work referral made.

20. On 7 September 2019, Master T was admitted to TNH. The presenting complaint was a 2-day cough, marked 'work of breathing' (**WOB**)[16], audible wheeze and a runny nose. It was noted that he had presented to the RCH and was admitted with the same symptoms 6 days earlier and that he had received prednisolone, salbutamol, nil IV, and was discharged after one day and was well for the following 2 days. Master T was discharged home from TNH after a 1 day High Dependency Unit (**HDU**) admission, with one further dose of prednisolone (1mg/kg) on 9 September (for 3 days total). A viral wheeze plan was provided to his grandfather.

21. On 10 September 2019, Dr Bahrami reviewed Master T and obtained a history of fever, cough and a blocked, runny nose for a few days. On examination Master T was afebrile[17] and there were no signs of respiratory distress with normal air entry and no recession or use of accessory muscles observed. He diagnosed a viral upper respiratory tract infection and recommended treatment with Panadol or Nurofen and fluids. He advised Master T's grandfather to bring him back to the clinic for further review if there was any deterioration in his condition.

22. On 16 September 2019, Master T presented to RCH with a cough, wheeze and respiratory distress. He was admitted from 16 to 18 September 2019 and discharged on montelukast[18] 4mg daily.

23. On 19 September 2019, Dr Bahrami reviewed Master T. He recorded that he had been to hospital and was awaiting an appointment at TNH, that he had recurrent wheezing needing IV aminophylline and he had been prescribed daily Prednisolone tablets. At the time of this review Dr Bahrami had not received a copy of the discharge summary from RCH but he believed he had received a copy of the letter from RCH to TNH dated 18 September 2019 which contained a brief summary of the treatment that had been provided. On examination Master T was afebrile, responsive and showed no signs of respiratory distress with normal air entry and no recession or use of accessory muscles observed but he did remain wheezy. He substituted the

[13] Ventolin is a brand name of salbutamol. Salbutamol is a 'bronchodilator' that relaxes the smooth muscle in the bronchi (air passages) to open them up and relieve wheeze.
[14] Atrovent is ipratropium. This is also an inhaled bronchodilator medication. Its mode of action is different to Ventolin and their effects can be additive.
[15] Dexamethasone is a steroid medication similar to prednisolone.
[16] WOB is the amount of energy or O_2 consumption needed by the respiratory muscles to produce enough ventilation and respiration to meet the metabolic demands of the body.
[17] Absence of fever.
[18] Montelukast is an asthma medication indicated for prophylaxis and chronic treatment of asthma. It acts via different mechanisms to other medications and supresses some of the mechanisms that cause airway inflammation. It is not a medication that is given intermittently for acute attacks of asthma.

Prednisolone tablets with Prednisolone syrup[19] for ease of administration and advised Master T's grandfather to wean it slowly and to continue with the administration of his Ventolin puffer.

24. On 20 September 2019, Dr Bahrami said he received the discharge summary from RCH and actioned this letter by selecting that Master T be recalled for a non-urgent appointment. He said that he could not specifically recall reviewing the discharge summary but it is likely that he selected that Master T be recalled for a non-urgent appointment because RCH had recommended follow up by his GP in 3-4 weeks' time. He also could not specifically recall whether he noted that Master T had been prescribed Montelukast daily and not Prednisolone.

25. On 22 September 2019, Master T presented to TNH with vomiting, diarrhea and cough. It is documented that he has been unwell for almost 2 weeks with intermittent viral symptoms and was discharged from the RCH 4 days ago (after a 2 day admission). Master T was managed at TNH (2 day admission) with viral induced wheeze. Hospital social work reviewed and offered further support to Mr T. Master T was cleared for discharge home for a GP review in 2-3 days.

26. On 25 September 2019, Dr Bahrami reviewed Master T. On examination Master T was afebrile with some minor wheezing in the chest but there were no signs of respiratory distress. He advised Master T's grandfather to continue the administration of Redipred 2.5ml and Ventolin and to return to the clinic for further review if there was any deterioration in his condition.

27. On 14 October 2019, Dr Bahrami reviewed Master T. He obtained a history of one episode of fever and a mild cough but no shortness of breath. On examination Master T was afebrile, hydrated and responsive and there were no signs of respiratory distress with normal air entry and no recession or use of accessory muscles observed. He advised Master T's grandfather to continue the administration of Redipred 2.5ml.

28. On 16 October 2019, Dr Bahrami reviewed Master T who presented with a wheeze. He ordered that Salbutamol 2.5mg and Atrovent 250mcg be administered via nebuliser. Master T's grandfather was asked to bring him back to the clinic later that afternoon for the administration of a second nebuliser.

29. On 21 October 2019, Master T presented to TNH ED with his mother with increased WOB since midnight. During presentation, the WOB remained normal. His wheeze resolved without

[19] Redipred is a liquid preparation of the steroid 'prednisolone'. Steroids as a treatment for asthma/wheezing and have the effect of reducing the underlying inflammation.

Ventolin. Master T was monitored for a period in the ED and discharged home with no wheeze and normal WOB.

30. On 28 October 2019, Dr Bahrami reviewed Master T. His grandfather reported a history of wheezing and mild WOB. On examination Master T was afebrile and wheezing but there were no signs of respiratory distress. Master T was administered Salbutamol 2.5mg via nebuliser and he noted that he looked better and his wheezing had improved once the nebuliser had been administered.

31. On 29 October 2019, Dr Bahrami reviewed Master T who presented with an audible wheeze which once again improved after he was administered Salbutamol 2.5mg via nebuliser. He said that given there was a positive response to treatment, a senior practice nurse commenced efforts to source funding for a portable nebuliser that could be used at home by Master T's family during periods of exacerbation.

32. On 30 October 2019 Dr Bahrami reviewed Master T after he had been brought back by his grandfather with wheezing and had been administered Salbutamol 2.5mg via nebuliser. He noted that Master T was feeling better and was no longer wheezing following the administration of the nebuliser. He also noted that Master T was still awaiting an appointment with a paediatrician at TNH and at his request a senior practice nurse at the clinic followed up with TNH to ensure that the referral was escalated as an urgent priority. He considered that it was appropriate to follow up Master T's appointment with a paediatrician at TNH rather than refer him back to the ED because his presentation with wheezing appeared to be chronic rather than acute, there had been no obvious deterioration since his last admission to TNH and his condition always improved once the nebuliser had been administered.

33. On 7 November 2019, a senior practice nurse at the clinic attended a meeting with Master T's grandfather and a family services caseworker and the urgency of the purchase of a portable nebuliser machine was discussed. The senior practice nurse also contacted TNH to follow up Master T's appointment with a paediatrician which had been scheduled on 4 November 2019 but Master T did not attend. This appointment was rescheduled with priority to 9 December 2019.

34. Dr Bahrami reviewed Master T for the last time on 11 November 2019. On examination Master T was wheezing but there were no signs of respiratory distress and he noted that he looked playful and happy. Master T's grandfather had received the portable nebuliser machine and he prescribed Ventolin Nebules 2.5mg (Salbutamol Sulfate) to be administered at home as needed once his grandfather had been shown how to use the machine.

Days before Master T's passing

35. On Thursday 21 November 2019, the temperature was 39 degrees Celsius, and it was noted to be extremely windy, and the doors and windows of Master T's home were kept closed to keep the pollen out. Master T became wheezy and required his Nebuliser. This treatment was successful and nothing further was required.

36. On Sunday 24 November 2019, Master T was at home with his grandfather. Throughout the day he was a little wheezy, as a result Mr T administered Nebuliser as they had been instructed to do.

37. At approximately 5.30pm, Master T ate dinner with his mother. His meal consisted of chicken casserole, a blueberry and strawberry yoghurt, and home cooked chicken nuggets. After he ate, Master T was bathed and again was a little wheezy, so Nebuliser was administered.

38. At approximately midnight Master T had a bottle of a mix of juice and water and a bottle of approximately 105ml of milk. He was again administered Nebuliser before he fell asleep. He went to sleep and was put to bed.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

39. Between 5.00 and 5.30am on Monday 25 November 2019 Ms T woke up to Master T coughing. She went and checked on him noting that he was also wheezing. Ms T gave him the remaining 105mls of milk from the midnight before and more Nebuliser.

40. Master T reportedly fell to sleep in her arms and she put him back to bed in his cot. He was placed in bed on his back with his face up, head on the pillow and two soft toys close by. This was the common way for him to sleep. She returned to bed and fell to sleep. She stated that she was exhausted and didn't wake until approximately midday.

41. At approximately 8.00am, Mr T stuck his head in the room and observed Master T laying on his stomach. He believed he was fine at that time and left for the city.

42. At approximately midday Ms T woke up, concerned that Master T hadn't stirred given the time. He would normally sleep through until 5.00 – 7.00am. It was at this time that she observed Master T laying on his stomach, with his head turned to the left and him resting on his crossed arms. This was a regular position for Master T to sleep in. His toy rabbit was off to one

side. She touched his leg and noticed that it was cold and hard. She immediately identified that something was wrong, took him out of the cot and placed him on the ground. She observed him to be blue to his face and arms.

43. At approximately 12.02pm, Ms T contacted triple zero. Ambulance Paramedics attended shortly after locating him on his back on the floor in his bedroom with a blanket underneath him. Mr T returned home at the same time the ambulance attended and ran into the house. Paramedics conducted an ECG and Master T was subsequently pronounced deceased.

44. Police attended the scene at 12.36pm and commenced an investigation. No visible signs of injury were observed. The Investigative Checklist completed by the Coroner's Investigator noted that Master T's bedroom contained a 'Childcare' brand white wooden cot with medium firmness foam mattress, a fitted sheet, a single pillow and a brown soft teddy. The pillow was used as he had asthma. Master T was wearing nappies and shorts.

45. There was no evidence of co-sleeping. Both Master T's mother and grandfather smoked, but said that it occurred outside the home.

46. Following their investigation, police found no evidence of suspicious circumstances surrounding Master T's passing.

Identity of the deceased

47. On 25 November 2019, Master T, born [redacted] 2018, was visually identified by his mother, Ms T.

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

Medical cause of death

49. Specialist Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy examination on 28 November 2019 and provided a written report of her findings dated 11 April 2020.

50. Dr Glengarry noted the following in her report,

The post-mortem examination showed a normally developed, male who was below the second centile for body weight with a head circumference and length at the 50th and above the 98th centiles respectively.

Examination of the lungs showed they were hyperinflated and had histologic features of chronic asthma. There was no superimposed infection. "Status asthmaticus" cannot be diagnosed by the autopsy. No other disease process was revealed by the autopsy examination or ancillary tests. In the absence of a competing cause of death and with the circumstances suggesting worsening asthma in the time period leading up to death, with autopsy findings confirming the presence of asthma, in my opinion it is reasonable to invoke this as the cause of death.

Ancillary testing including biochemistry and microbiology examinations did not show lethal abnormalities. There was no evidence of severe infection either microscopically or by measurement of inflammatory markers. There was no evidence of severe allergy (anaphylaxis).

No injuries were present on the skin, nor were demonstrated either radiologically or by the autopsy examination.

On the basis of the information available to me at this time, I am of the opinion that this death is due to natural causes.

Toxicological analysis of samples obtained at the time of the post-mortem examination showed methylamphetamine (and its metabolite amphetamine) in the hair but not the blood. Cannabis and codeine were also detected in the hair.

a. *Smoke exposure is a recognised trigger for asthma.*

b. *Salbutamol (Ventolin) was looked for but was not detected. Following inhalation, salbutamol acts within the airways on the bronchial smooth muscle and after inhalation, the drug is initially undetectable in the blood. After some hours, low concentrations may be seen. As such, the finding of no salbutamol in the blood does not imply that the deceased was not given his Ventolin.*

51. Dr Glengarry formulated the cause of death as *Chronic Bronchial Asthma* and as noted above, that the death was due to *natural causes.*

52. I accept Dr Glengarry's opinion.

FURTHER INVESTIGATION

Coroners Prevention Unit review

53. During the coronial investigation I referred this case to the CPU to review the appropriateness of the medical management of Master T's asthma.

54. Master T had recurrent episodes of wheezing, either due to viral induced wheeze (**VIW**) or asthma. The CPU noted that clinically it is sometimes difficult to diagnose asthma as opposed to VIW in small children who suffer wheezing in response to the frequent viral infections often experienced by this age group.

55. From the medical records the CPU considered that it was clear that he was on almost constant treatment for wheezing, indicating there was chronic and ongoing inflammation in his airways, even when he appeared not to have had UTRI symptoms. It was therefore likely that he had developed chronic asthma, rather than just episodic viral wheeze.

56. The CPU noted that asthma may be triggered by exposure to a range of things, including pollen, dust, spores, food, cold temperature, exercise, smoke, fumes and other irritants. The presence of methamphetamine and cannabis residues in Master T's hair is suggestive of environmental exposure to smoke, and there is at least one reference in ambulance notes of him becoming wheezy after exposure to cigarette smoke.

57. Master T was treated with conventional asthma drugs, including a course of prednisolone to reduce inflammation and Ventolin and Atrovent to open the airways when wheezy. Master T was able to obtain a nebuliser around 11 November 2019 and was provided with the appropriate form of Ventolin to use with it.

58. The CPU noted with regard to the effectiveness of delivery of bronchodilators by nebulisers[20] versus 'spacer12' devices, that spacer devices are considered to be as at least as effective as nebulisers.

59. The CPU considered that the medical management of Master T's wheeze and asthma was along recognised guidelines, however identified a potential issue regarding the drug 'montelukast'. Montelukast is an asthma medication indicated for prophylaxis and chronic treatment of asthma. It acts via different mechanisms to other medications and supresses some of the mechanisms that cause airway inflammation.

60. The CPU noted that at his last admission to the RCH, the discharge plan was to commence Master T on montelukast. The advice included the following,

Letter dated 18/9/2019, sent via fax to Northern Health Outpatient Paediatrics

[20] A nebuliser is a device that is driven by gas flow (air or oxygen) to aerosolise a medication such as Ventolin, into a fine mist that is then inhaled via a mask into the lungs.

To whom it may concern, Master T is a 15-month old male who has had 3 presentations over the last fortnight for viral induced wheeze. He has presented to Royal Children's Hospital twice, and Northern Health once over this time period. He has required IV therapy twice during this period. His most recent admission to RCH was from 16/09/2019 to 18/09/2019. During this admission he was managed with ventolin, ipratropium, IV aminophylline, and prednisolone. Upon discharge he was commenced on montelukast. He requires general paediatric follow-up for management of his viral induced wheeze, and assessment of his response to montelukast. Best regards, Dr. Natalie Astbury Intern - General Medicine Short Stay Unit (Royal Children's Hospital)

61. It was apparent that the GP and TNH paediatric outpatients were to review Master T's response to this new medication however this did not occur despite further attendances with both services.

62. The CPU noted that montelukast is not a first line 'preventer' medication and it is not used for treatment of acute attacks. In addition, not all children will respond to the medication and that most likely any response would be incremental rather than 'miraculous'. The CPU further noted that it would have been prescribed because of the apparent poor response to the standard steroid medication. The CPU were unable to say if montelukast would have made any difference to the outcome in this case.

63. I accept the advice of the CPU on these matters, and consider that there is no basis upon which to conclude that the provision of montelukast would have altered the outcome for Master T.

<u>GP response regarding the provision of Montelukast</u>

64. Dr Bahrami said,

Unfortunately I do not specifically recall anything relating to the prescription of Montelukast or the recommendation for follow up of this medication and in retrospect it appears that there has been an oversight in this regard. It is possible that this may have occurred because Master T attended the Northern Hospital shortly after his discharge from the Royal Children's Hospital and therefore I may not have been prompted to review the earlier discharge summary. However, I accept that I should have made enquiries as to whether this medication was being administered to Master T as prescribed by the Royal Children's Hospital.

NH response regarding the provision of Montelukast

65. NH were asked to provide comment on the above referral, and following their review of the issue and their systems concluded that the RCH correspondence of 18 September 2018 was not received by NH, that no referral was registered on their patient management system (**PM**) and that registering a referral on PM is the first step in managing any referral. It was noted that the medical record contained a fax from the RCH to NH sent on 18 September 2019, which according to the RCH fax server stamp on it contained 3 pages, however NH's medical record only has pages two of three and three of three. The cover sheet of that fax contains 2 pages (including that sheet).

66. It was further noted,

Northern Health is acutely aware of the potential for patient management issues to arise from poor or missed communication between medical practitioners and health services. In that regard, Northern Health notes Coroner Carlin's Finding into the death of Mettaloka Malinda Halwala (COR 2015 5857) and her Honour's comments on the use of faxes in the medical profession.

From 1 October 2020, Northern Health Specialist Clinics (outpatient clinics) have been working with GPs within our catchment to phase out the use of referral by fax and encouraging them to use electronic smart forms to refer patients to Northern Health. Whilst Northern Health is able to exercise some control over how it receives referrals from GPs, it does not have any meaningful control of the greater health system, including health services and hospitals.

RCH response regarding the provision of Montelukast

67. RCH similarly undertook an investigation and noted the following,

- The referral letter was faxed by the doctor from Dolphin ward to TNH and GP on 18 September 2019 directly via the fax portal in the RCH's Electronic Medical Record (**EMR**). The RCH fax logs for 18 September 2019 identified this fax was sent successfully from the RCH.

- The doctor from Dolphin ward also printed the referral letter and manually faxed a copy of the letter which was addressed to TNH medical records department. This letter would have·been one page and a cover page, so the fax should have been two pages. The RCH fax logs show the fax that went to the TNH contained three pages and it was sent successfully.

The logs do not retain a copy of the documents that were sent so it us unclear what the third page of the fax was.

- The RCH discharge summary in relation to the admission 16-18 September 2019 was identified to have been sent electronically to the nominated GP by the Argus system (an electronic information sharing platform.

68. RCH further advised that following consultation with their multiple stakeholders through the process of a critical incident review, there were several issues identified relating to the use of fax in communicating patient information, including,

    - Fax is still used in most areas of RCH;

    - External health care providers request patient information to be faxed;

    - There is always a risk that information is not received. The fax machine from the sender may state the information was successfully faxed however this might not be the case for the receiver;

    - There have been previous coronial recommendations stating that fax is not a reliable communication device and should not be used for communicating patient information. There have been no public health system changes despite these recommendations;

    - The stakeholders outlined there is no driver to change the use of fax at this time, given the high utilisation of this device to communicate information;

    - The stakeholders believe the directive to cease using fax for patient information needs to be driven by the Department of Health; and

    - The RCH Privacy Policy does not permit the use of email for communicating patient information.

69. In addition, the RCH advised that further exploration of the EMR capability and the possible phasing out of fax through using EMR identified:

    - The EMR team in the United States use a system called a transfer centre that potentially could improve communication between all stakeholders. This is future state and on the horizon for the Parkville EMR team;

- The communication problems associated with the use of fax are well known however the 'fix' for this is very complicated due to the multiple systems that are involved and that currently there is no one platform that can replace fax machines; and

- Argus is a communication platform which is currently use to communicate with some stakeholders (mainly GPs). This platform is not applicable to all types of patient communication and only if the recipient has an Argus identification code.

70. RCH advised the Court that they would write to Safer Care Victoria outlining the patient safety issues identified through the use of fax as highlighted from their critical incident review.

Child Protection Involvement with Master T

71. Master T was subject to five reports made to Child Protection from [redacted] 2018 to 18 September 2019, and one section 38 consultation[21] on 12 November 2019.

72. As part of the investigation therefore, Child Protection was asked to address specific questions following which a statement was provided from Ms Martin as noted above. Those questions included,

- The response to the referral from RCH, including efforts to ensure that Master T's primary carer was supported to manage his acute asthma.

- Any assessments on the impact of Master T's primary carer giver's substance abuse on Master T's care needs proximate to his death (six months preceding death).

- Any assessments to ensure that Master T's primary caregiver had adequate support or training to enable Master T's care needs (including his known health issues), to be met proximate to his death (six months preceding death).

- Any assessments to ensure that his primary caregiver received adequate support to address his disclosed mental health issues (including depression and suicidal ideation noting its potential impact on Master T's care (including management of his known health issues) for the period six months preceding his death.

[21] Section 38 of the Act enables a registered community and family service to consult and seek advice from the department's Community Based Child Protection (practitioners) to undertake risk assessments and inform decision making. This is to allow for opportunities to offer effective earlier intervention and prevention services before there is a need for child protection intervention and supports the earlier identification of cumulative harm to children as well as helping to ensure that families receive services to improve outcomes for vulnerable children and their families.

73. Child Protection's response to these questions is set out below.

74. On 18 September 2019, Child Protection was advised of a referral to Child and Family Information Referral and Support Teams (Child FIRST[22]) by RCH for individual and family support for Mr T. It was noted that Child Protection conducted its own investigation concurrent with the referral.

75. Activities which followed included visits to the family home (with SIDS safety assessed and discussed), identification of family needs as related by Master T's grandfather and liaison with Master T's GP clinic (who advised that Master T's immunisations were up to date, weekly appointments were taking place, Master T was on target regarding his age and stage of development and there were no concerns for Master T being in his grandfather's care). It was further noted following an admission to NH, that whilst Master T *appeared to be thriving*, his grandfather required support following which a referral to Integrate Family Services (**IFS**) was made (including support for a nebuliser, pram, formula and Ventolin as well as housing, childcare and medical needs).

76. Child Protection *assessed that Mr T was able to fully care for Master T and ensure that he attended all of his medical appointments. Mr T was able to provide all care tasks for Master T and had been observed to be loving and nurturing towards him.*

77. Child Protection further noted that *there was no advice from services involved that training was required for Mr T to manage Master T's medical health issues*.

78. The Court was however advised that a reflective practice[23] session with practitioners directly involved in decision-making and oversight of Master T's care between [redacted] 2018 and November 2019 was convened which *identified that a more comprehensive kinship assessment could have been undertaken, support to kinship carers, and exploration of substance use and its impact on caregiving of an infant would benefit practitioners in risk assessments and decision-making*.

79. In addition, Child Protection advised that since Master T's passing a new risk assessment framework has been introduced. It was noted that SAFER[24] *provides greater clarity around what information or evidence may be considered verified or confirmed, including evidence such*

[22] Child FIRST (Child and family information, referral and support teams) are the entry point into family services. Child FIRST teams are located in sites across Victoria and is delivered in local area by community service organisations. Child FIRST, as the access point for family services, is progressively transitioning to The Orange Door.

[23] The purpose of this session was to provide an opportunity for staff to critically reflect on decision-making for Master T.

[24] The five key practice activities are: Seek, share, sort and store information and evidence. Analyse information and evidence to determine the risk assessment. Formulate a case plan. Enact the case plan; and Review the risk assessment.

as photos and a chronology of events provided by a childcare centre. The identified evidenced based factors are then given greater weight when determining the consequence and probability of harm to a child.

FINDINGS

80. Pursuant to section 67(1) of the Act I make the following findings:

a) the identity of the deceased was Master T, born [redacted] 2018; and

b) his passing occurred on 25 November 2019 at [redacted], [redacted], Victoria from *Chronic Bronchial Asthma,* in the circumstances described above.

COMMENTS

81. Pursuant to section 67(3) of the Act, I make the following comments connected with Master T's passing.

82. It was apparent that despite RCH doing everything necessary to communicate to TNH the planned provision of montelukast to Master T, the communication (through the use of facsimile) to TNH did not appear to achieve its intended outcome in this case. Whilst it is not possible to say whether this would have made any difference to the outcome for Master T, the investigation identified an important system issue and potential prevention opportunity in future cases (where the outcome may have been altered).

83. As noted by both health services there have been earlier coronial recommendations on this issue. Coroner Rosemary Carlin (as she then was) highlighted with respect the use of facsimile in medical context,

It is difficult to understand why such as antiquated and unreliable means of communication persists at all in the medical profession.[25]

84. Therefore, based on these matters and the further learnings arising from this case, I am directing that this finding be provided to Safer Care Victoria (noting that RCH has similarly done so) to consider whether it is appropriate for Health Services to review channels of communication in light of the potential issues which may raise with the use of facsimile as an effective form of communication in a medical setting and its potential for harm being caused.

[25] Investigation into the death of [redacted], COR 2015 5857, dated 10 May 2018.

85. I convey my sincere condolences to Master T's family for their loss and acknowledge the tragic circumstances in which his death occurred.

86. Pursuant to section 73(1B) of the Act, I order that this finding (in redacted form) be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ms T, Senior Next of Kin

Dr Saeid Bahrami

Royal Children's Hospital

The Northern Hospital

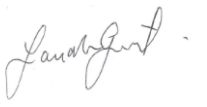
Safer Care Victoria

Department of Families, Fairness and Housing

Commission for Children and Young People

DS, Victoria Police, Coroner's Investigator

Signature:



CORONER SARAH GEBERT

Date: 25 January 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.