IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 1665

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JACINTA HEFFEY, Coroner having investigated the death of PRUSEYUS SHARP

without holding an inquest:
find that the identity of the deceased was PRUSEYUS LILY SHARP
born on 10 February 2009
and the death occurred on 21 March 2009
at Royal Children's Hospital, Flemington Road, Parkville, Victoria 3052

from:

1a. HYPOXIC BRAIN INJURY SECONDARY TO PNEUMONIA AND PULMONARY HAEMORRHAGE

Pursuant to Section 67(2) of the *Coroners Act 2008*, I make these findings with respect to the following circumstances:

1. Pruseyus Sharp was the second child born to her parents, Carletta Millar, then 20 years old, and Troy Sharp, on 10 February 2009, at 35-36 weeks gestation at Wodonga Hospital. Apart from early problems with jaundice, which were successfully treated with light therapy, she was doing well, gaining weight and breastfeeding well. Her mother regularly took her to the maternal and child health nurse and there were no concerns noted.

2. On the evening of 19 March 2009, her parents decided, with the agreement of the maternal health nurse, to move Pruseyus from her bassinet in their room to a cot in what was to be her bedroom. Prior to this, she had been sleeping well, waking every three to four hours or so for a feed and/or to have her nappy changed. Her mother had noticed nothing unusual about her prior to that night and she did not seem unwell. She just seemed "like a sooky baby".

3. Although Pruseyus did not wake during the night, her mother checked on her every few hours. She was put down to sleep for the night at 11.30pm. She was checked at about 3.00am. She did not seem interested in the formula milk offered, drinking only about 15 ml, (she normally drank about 45 minutes on the breast). She was next checked at 5.00am. She had not stirred and was not interested in a feed. She still had not woken at about 8.00am. At 9.00am her mother woke her. She was limp and floppy and one eye only partially opened. She had purple discolouration around the elbows. Her father cuddled her to his chest for about 40 minutes in an effort to warm her. Only after this time was assistance sought, namely from his sister whom they contacted, who recommended an ambulance be called immediately.

4. After being taken by ambulance to Albury Base Hospital she was then airlifted to the Royal Children's Hospital arriving in the neo-natal unit at about 6.30pm. At the time of arrival, she was found to have a slow heartbeat, with fixed dilated pupils and a tight fontanelle (due to acutely raised intracranial pressure, which in turn caused downward pressure on the brain stem). Notwithstanding heroic measures taken in an attempt to reverse the situation, a CT scan revealed severe and widespread cortical infarction. She suffered a moderate pulmonary haemorrhage. She suffered a cardiac arrest whilst waiting for an urgent MRI and although resuscitated again suffered a second, and on this occasion massive, pulmonary haemorrhage. After consultation and review by the neurosurgical team, it was decided that her condition was irreversible, extraordinary intensive care was ceased after discussion with her parents and she was allowed to die in their presence.

5. An autopsy was conducted at the Victorian Institute of Forensic Medicine, which confirmed the presence of pneumonia and found evidence of pulmonary haemorrhage. No bacterial organism was identified (however, Pruseyus had been treated extensively with anti-biotic therapy) but the picornavirus was detected in the tissue of each lung and in nasal aspirate. There was no evidence of any injuries, accidental or non-accidental.

6. An expert opinion was obtained by the Coroners Court from Dr Luke Sammartino, a Consultant Paediatrician who reviewed the Inquest Brief and hospital records. His impression was that the lung disease was the primary event with the brain findings caused by consequential anoxia/hypoxia. The precise mechanism causing the lung disease is difficult to identify and mortality in the case of bronchiolitis/pneumonitis is less than 1% of those affected. Atypically for an infection, Pruseyus did not have a fever but rather her body

temperature had dropped. There is no evidence that she had other symptoms that would normally be associated with lung infection such as cough, wheeze or breathlessness. Dr Sammartino was of the view that this was a case of severe apnea with minimal other symptoms or signs prior to Pruseyes' presentation on the morning of 20 March 2009.

7. Dr Sammartino commented that the evidence does not paint a picture of deliberate parental neglect but "cardinal errors" were "seemingly made on their part". He described their failure to seek medical attention for 40-45 minutes as "a calamitous mistake with crucial time lost". However, he does not suggest that the outcome, had medical attention been sought at 9.00am, would *necessarily* have been different given that she was clearly extremely unwell at that time.

8. Whilst there had been some history in the past involving conflict with the local hospital, there is no evidence that this factor exercised the minds of the parents. Rather it is likely to be more of a case of young parents not appreciating the symptoms as being sufficiently significant to warrant immediate action but rather adopting a "wait and see" approach. Dr Sammartino recommends a "help-line" be set up for young parents in this situation.

Recommendations:
Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

1. I make the recommendation that a "help- line" be established to assist young parents who seek information about unusual features noted in their infants. The existence of such a help-line and the types of features that might register concern could form part of information provided by the maternal and child health nurse system.

2. I propose that this Finding and the accompanying Recommendation be forwarded to the Department of Education and Early Childhood Development for consideration of the Recommendation.

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

The family of Pruseyus Lilly Sharp,
Investigating Member, Victoria Police,
Interested parties.

Signature:

JACINTA HEFFEY
CORONER
3 July 2012