IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 003004

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Baby of Alpitaben and Jaykumar Patel
Date of birth:	27 May 2020
Date of death:	6 June 2020
Cause of death:	1(a) Unascertained
Place of death:	The Royal Childrens Hospital, 50 Flemington Road, Parkville, Victoria, 3052

INTRODUCTION

1. The baby of Alpitaben and Jaykumar Patel (**Baby Patel**) died on 6 June 2020 at 10 days of age. Baby Patel was the second child to his parents, Alpitaben Patel (**Alpitaben**) and Jaykumar Patel (**Jaykumar**).

2. Alpitaben's pregnancy was unremarkable. Baby Patel was born at 36 weeks gestation on 27 May 2020 via vaginal delivery at Werribee Mercy Hospital (**WMH**). He was born in good condition, with APGAR[1] scores of 8 at one minute of life, and 9 at five minutes of life. His birth weight was 2595g. Regarding risk factors for neonatal sepsis, it was noted that there was no prolonged rupture of membranes, and no maternal fever. Alpitaben's group B streptococcal status was unknown.[2]

3. At about 16 hours of age, Baby Patel was noted to be hypothermic, hypoglycaemic, and feeding poorly. He was admitted to the special care nursery. He was placed in an *isolette* to maintain his temperature. He was started on top-up feeds with formula after breastfeeding and his blood sugars normalised. No further investigations were done at the time. Baby Patel was discharged home on 29 May 2020.

4. A domiciliary midwife visit occurred on 30 May 2020. Baby Patel had been breastfeeding and his weight loss was minimal. He was described as alert and active at the visit. A subsequent domiciliary midwife visit occurred on 1 June 2020. Baby Patel had been breastfeeding, but no formula top-ups were being given although these had been recommended. It was noted that he had had further weight loss of 80g, however his overall weight loss was acceptable with no excessive loss from birthweight. The midwife noted short periods of alertness. There was a plan for a reweigh in 48 hours, however this appointment was not scheduled.

THE CORONIAL INVESTIGATION

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

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[1] The APGAR score evaluates a baby's physical wellbeing at birth, helping to provide a general understanding of how well each baby makes the physical transition to independent life from their mother. The APGAR score is measured at one minute and five minutes of life routinely. The APGAR score ranges from 0-10, with a lower score indicating a poorer outcome.

[2] A bacterium that can be a commensal of the vaginal tract, which can cause severe infection of neonates if passed on during labour and delivery. A vaginal swab of the mother is done between 36-38 weeks of pregnancy.

6. 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.

7. 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.

8. Coroner John Olle initially held carriage of the investigation into Baby Patel's death. I took carriage of the investigation in July 2023 for the purposes of conducting discrete additional investigative steps and making findings.

9. This finding draws on the totality of the coronial investigation into the death of Baby Patel including evidence contained in the coronial brief. 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.[3]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

10. On 4 June 2020, Jaykumar called the Werribee Mercy Hospital lactation consultant, Sue Littlechild (**Ms Littlechild**) at about 3:30pm. He advised that Baby Patel was difficult to wake and was too sleepy to breastfeed for the last 24-48 hours. He noted Baby Patel seemed to be worsening. He had had three to four dark yellow nappies and two yellow stools in 24 hours. Ms Littlechild discussed with the paediatric medical team who advised the family to present to the emergency department at Werribee Mercy for review as soon as possible, where they would be reviewed by a paediatrician.

11. Baby Patel was triaged at the Werribee Mercy Hospital emergency department at 4:50pm with a triage category of 3,[4] and a presenting complaint of '*poor oral intake*'. The initial triage

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[3] 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.

[4] The Australasian Triage Scale (**ATS**) is a clinical tool used to establish the maximum waiting time for medical assessment and treatment of a patient in Emergency Departments. The ATS utilises five categories from Category 1 – an immediately life-threatening condition that requires immediate simultaneous assessment and treatment – to Category

nursing assessment was documented as '*not taking oral intake…3 wet nappies today…cool to touch and hard to rouse…slight jaundice colour observed.*'[5]

12. The initial observations at 4:44pm showed temperature was hypothermic at 35.8 degrees Celsius, a heart rate of 152 beats per minute, respiratory rate of 32 breaths per minute, and oxygen saturation of 93% (considered to be within normal ranges).

13. A note entered at 6:11pm by emergency department doctor, Dr Nuseibeh, states that '*nursing staff report the patient was taken home after 30 minutes as parents felt they had waited too long*.'

14. Baby Patel was subsequently taken by his parents to the Maternity Assessment Unit at Werribee Mercy Hospital, due to the long wait at the Emergency Department. He was given a triage category of 3, at 5:20pm. At that stage his heart rate was low at 115 beats per minute, but his respiratory rate at 50 breaths per minute was within normal limits. No other vital sign observations were documented on triage. The triage notes document '*sleepy baby, not feeding…unable to get temperature reading*.' The nursing assessment stated, '*wet nappies < 3 in 24 hours, feeding poorly, jaundice, drowsy and vomiting, lethargic, normal fontanelles*.'

15. Baby Patel had an unrecordable temperature on four different machines. A skin probe was applied which showed hypothermia with a temperature of 33 degrees Celsius. He was placed under a radiant warmer. Baby Patel was initially assessed by the paediatric registrar and resident at approximately 5:50pm (one hour after initial presentation to hospital). He appeared jaundiced, cool to touch, with a mottled appearance and a delayed capillary refill,[6] and was minimally responsive to examination. He was also noted to have apnoeas[7] on initial assessment. He was subsequently transferred to the Special Care Nursery for resuscitation and rewarming at 6:27pm. The paediatric consultants Dr Kathy McMahon (**Dr McMahon**) and Dr Rafaella Armiento (**Dr Armiento**) were notified given Baby Patel's unwell appearance, with concerns for sepsis, at about 6:27pm.

16. On arrival at the Special Care Nursery, Baby Patel was rewarmed with bubble wrap and a heater. He was noted to be bradycardic on arrival with a heart rate of 90-100 beats per minutes.

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5 – a chronic or minor condition which can be assessed and treated within two hours. A patient with triage category 3 should have a maximum waiting time of 30 minutes.

[5] Yellow tinge to skin which commonly occurs in the neonatal period as a result of high bilirubin. There are multiple causes of jaundice.

[6] A measure of the time it takes for a capillary bed on the skin to regain colour after pressure has been applied to cause blanching. A prolonged capillary time may indicate the presence of circulatory shock.

[7] Periods of cessation of breathing.

Initial attempts at intravenous access were unsuccessful, hence an emergent intraosseous line was inserted into his left leg.[8] A bolus of normal saline, antibiotics (cefotaxime and benzylpenicillin), and antiviral medications were administered, followed by an infusion of fluids. Baby Patel showed improvement in his tone, colour, and reactivity, but continued to have apnoeas.

17. Investigations were sent including blood culture, gas, and a chest X ray. This showed a mild mixed acidosis with a pH of 7.30, and lactate 2.1.[9] The chest X ray was reported as showing no clear evidence of pneumonia.

18. At approximately 7:00pm, paediatrician Dr Datta Joshi (**Dr Joshi**) was called to attend for assistance and took over care from Dr McMahon and Dr Armiento. Two further peripheral intravenous lines were inserted. The Paediatric Infant Perinatal Emergency Retrieval (**PIPER**)[10] team was notified at 7:22pm and retrieval was requested. They recommended adding another antibiotic (flucloxacillin) and supporting oxygenation. Baby Patel was commenced on nasal prong High Flow oxygen therapy.

19. The PIPER team arrived at the hospital at 8:06pm. At that time, Baby Patel was found to be hypotensive. Dobutamine was commenced.[11] The PIPER neonatal consultant was also called in to assist.

20. Multiple unsuccessful attempts at intubation were made by the PIPER fellow, Dr Joshi and two members of the Werribee Mercy Hospital anaesthetic team. When PIPER consultant Dr Jenny Sokol (**Dr Sokol**) arrived, she initially successfully intubated Baby Patel, however the endotracheal tube[12] subsequently became dislodged and was removed. A laryngeal mask airway[13] was placed instead and adequate ventilation was able to be achieved. A plan was made for direct admission to the operating theatre at Royal Children's Hospital (**RCH**) with the anaesthetic and ENT team present.

21. Baby Patel arrived at RCH at 1:00am on 4 June 2020, and intubation was attempted by the anaesthetic team in the operating theatre. This was successful on the third attempt, however

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[8] Needle inserted into the bone marrow to give medications/fluids. Used in emergency situations where intra-venous access is unable to be achieved.

[9] Cells are forced to metabolise glucose anaerobically, which leads to lactate formation. Therefore, elevated lactate is indicative of tissue hypoxia, hypoperfusion, and possible damage.

[10] Statewide paediatric and neonatal retrieval service, based at Royal Children's Hospital.

[11] An inotrope used to increase the heart rate and force of heart contractility to improve blood pressure and perfusion (increase cardiac output).

[12] Placement of a flexible plastic or rubber tube into the trachea (windpipe) to maintain an open airway.

[13] Tube that sits above the epiglottis, and helps to keep the airway open.

he was very difficult to ventilate, with subsequent desaturation and cardiac arrest. CPR was commenced and an emergency tracheostomy[14] was placed by the ENT team at 1:30am due to concerns about secure airway control. Multiple rounds of adrenaline were administered throughout the resuscitation period. Resuscitation was ceased after around 30 minutes when signs of life were noticed. The decision was made to support with extracorporeal membrane oxygenation (**ECMO**)[15] until the neurological sequelae was better defined.

22. Baby Patel showed signs of poor neurology, and a CT brain scan was performed. This showed loss of grey-white matter differentiation, raising concerns about hypoxic-ischaemic encephalopathy.[16] Following discussion with the family, the decision was made to begin palliative care. Invasive supports were withdrawn at 3:00pm, and Baby Patel passed away at 4:04pm on 5 June 2024.

IDENTITY OF THE DECEASED

23. On 6 June 2020, Baby of Alpitaben and Jaykumar Patel, born 27 May 2020, was visually identified by his father, Jaykumar Patel, who signed a formal statement of identification to that effect.

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

MEDICAL CAUSE OF DEATH

25. On 9 June 2020, Forensic Pathologist Dr Sarah Parsons (**Dr Parsons**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy. Dr Parsons reviewed the Victoria Police Report of Death Form 83, post-mortem computed tomography (**CT**) scan, medical deposition, SUDI checklist, and medical records and provided a written report of her findings. A neuropathology report was provided by Dr Linda Iles, Forensic Pathologist at the VIFM.

26. The cause of death was not able to be determined following an autopsy and ancillary tests.

27. The clinical history was in keeping with sepsis/meningitis, however there was no evidence of meningoencephalitis at autopsy. It is impossible to confirm or refute a diagnosis of sepsis on

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[14] Surgical procedure in which an opening is cut from the neck into the trachea (windpipe) to that a tube can be inserted to assist breathing.

[15] An extracorporeal technique of providing prolonged cardiac and respiratory support to persons whose heart and lungs are unable to provide an adequate amount of gas exchange or perfusion to sustain life.

[16] A condition in which the brain doe not receive enough oxygen. This condition refers to an oxygen deficiency to the brain as a whole, rather than a part of the brain.

autopsy findings alone after a period of ventilation. At autopsy, the deceased had widespread pneumonia however had been on a ventilator for at least 24 hours. This is most likely a consequence of ventilation rather than the initiating event.

28. Whilst the airway was narrow, there was no congenital abnormality identified. There was a fibrinous polyp at the site of the tracheostomy which has occurred as a consequence of the tracheostomy placement.

29. Metabolic samples showed post-mortem changes only.

30. The post-mortem CT scan and skeletal survey did not show any abnormality.

31. A left parietal subdural haemorrhage undergoing early organisation and organising subarachnoid haemorrhage was identified on neuropathology review. The exact cause of this is unknown, however may be birth related. There are no features to suggest significant meningoencephalitis. Two microscopic foci of white matter necrosis are identified but this change is not widespread.

32. There was pontosubicular apoptosis and scattered changes within the cortex and cerebellum in keeping with hypoxic ischaemic injury.

33. Microbiological samples on nasopharyngeal aspirate CSF, lung samples, liver and spleen have not detected any viruses or bacteria that could account for death. Procalcitonin was raised however the deceased had evidence of pneumonia.

34. Toxicological analysis on post-mortem specimens detected the presence of atropine and lignocaine. These were administered by the hospital.

35. Dr Parsons provided an opinion that the medical cause of death was 1 (a) unascertained.

36. I accept Dr Parsons' opinion.

FAMILY CONCERNS

37. Alpitaben and Jaykumar raised concerns with the medical care and management of Baby Patel. As per the statement provide by Werribee Mercy Hospital, the family had a number of meetings with the hospital and have raised concerns regarding the following:

    a) The lack of interpreter in the Emergency Department, or option for Jaykumar to be present;

b) The lack of interpreter usage in antenatal clinics;
c) The lack of recognition of how unwell their baby was;
d) That the jaundice may not have been recognised;
e) Distress regarding number of intubations attempted by the resuscitation team;
f) Emergency department waiting times; and
g) Cold post-natal ward.

CPU REVIEW

38. Following receipt of the family's concerns, and in the interests of a comprehensive investigation, the Coroners Prevention Unit (**CPU**) undertook a review of the care provided to Baby Patel. The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

Statement from Werribee Mercy Hospital

39. As part of the CPU review, a statement was sought from Dr Jeffrey Kirwan, Chief Medical Officer at Werribee Mercy Hospital, and received on 16th March 2022.

40. Therein, it was noted, *inter alia*, that the case was referred to Safer Care Victoria, however withdrawn when further review indicated that a notification was not necessary. The hospital then conducted a Root Cause Analysis (**RCA**), with a panel comprising of the Clinical Risk Manager, Associate Nurse Unit Managers, and Nurse Unit Managers of the emergency department, maternity assessment unit, midwifery in the home, and the Clinical Director of Paediatrics and Special Care Nursery.

41. The case was also presented at the paediatric and emergency department Morbidity and Mortality Meeting, the Women's and Children's Program quality meeting, the Acute Medical program quality meeting, and the Deteriorating Patient Committee meeting.

Review and assessment of contributing factors

a) Lack of 'Maternity in the Home' follow-up

42. Baby Patel was seen on home visits on 30 May 2020 and 1 June 2020. During the visit on 1 June 2020, it was noted by the domiciliary midwife that Baby Patel had been breastfeeding,

but no formula top-ups had been given, as had been recommended during the previous visit. It was noted that he had had further weight loss of 80g however overall, his weight was acceptable with no excessive loss from birthweight. There was a plan for reweigh in 48 hours, on 3 June 2020.

43. However, this appointment does not appear to have been made, as there is no documentation of a follow-up appointment on 3 June. Baby Patel was therefore not seen between 1 June and the eventual presentation to the emergency department on 4 June. Given the concern of ongoing weight loss on the review on 1 June, it was important that this baby was reviewed in a timely fashion by the home midwives.

44. The hospital review process has identified this issue in their RCA, identifying that the *"Maternity in the Home clinicians are responsible for clinical assessments and scheduling appointments. The clinician patient load was high, and an administrative error was made resulting in no follow up appointment being booked."*

b) Triage category in Emergency Department

45. Baby Patel received a triage category of 3, requiring him to be seen by a doctor within 30 minutes. The triage category of 3 was inappropriate, as he was a neonate with abnormal vital signs (hypothermia) with triage notes documenting an unwell neonate.

46. In particular, the CPU considered that many findings which were recorded on assessment at triage were not identified appropriately as signs of an unwell/septic neonate and therefore not triaged appropriately. These included that Baby Patel had a history of lethargy or increased sleepiness, poor feeding, prematurity, Group B Strap (**GBS**) status, and <4 wet nappies in 24 hours, and upon examination presented with features including jaundice, lethargy or decreased activity, poor feeding, reduced urine output and difficulty rousing. The CPU considered that taking into account these criteria, Baby Patel should have received at least a triage 2 (requiring review within 10 minutes).

47. The inappropriateness of the triage category is acknowledged in Dr Kirwan's statement, who confirmed that the hospital endorses the Australasian Triage Scale and Baby Patel was not triaged in accordance with the same.

48. As per the RCH Guideline 'Recognition of the Seriously Unwell Neonate and Young Infant',[17] Baby Patel met multiple criteria for an unwell neonate as documented at triage. Whilst these signs and symptoms were recognised on assessment at triage, they were not identified appropriately as signs of an unwell/septic neonate, and therefore not triaged accordingly.

49. These guidelines state that any neonate and young infant who appears unwell should be assessed promptly and discussed with a senior doctor. Therefore, Baby Patel should have received at least a triage category 2 (requiring review within 10 minutes).

50. This inappropriate triage in the emergency department meant that Baby Patel was not seen promptly, delaying medical assessment and management. Due to the anticipated wait time, Baby Patel's family then went to the Maternity Assessment Unit where he was reassessed, and again triaged inappropriately (which is addressed further below). This meant that overall, Baby Patel was seen by a paediatric staff member one hour after presentation to hospital.

51. The Werribee Mercy Hospital RCA identified the inappropriate triage at the ED as an issue, stating, "*the triage process for neonates is not included in the local triage procedure. The triage nurse may have been unfamiliar with the local guideline which may have contributed to the ED triage process not being followed"*.

52. It also identified the issue that "*the triage process for neonates in ED is different to that of adults, and a failure to appreciate this may have contributed to the neonates ED triage process not being followed*".

*c) Inappropriate Triage in Maternity Assessment Unit (**MAU**)*

53. Baby Patel was given a Triage category 3 in the MAU, which was also inappropriate. A heart rate of 115 beats per minute is considered bradycardic as per the RCH guidelines, with normal values of 120-185 beats per minute. The medical notes also indicate practitioners were unable to get a temperature reading. The CPU noted that this in itself should have prompted urgent review, as an inability to get a temperature reading is an extremely abnormal finding.

[17] Recognition of the seriously unwell neonate and young infant' is a guideline freely available on the internet through the Clinical Practice Guidelines. It has been endorsed by the Paediatric Improvement Collaborative. [Clinical Practice Guidelines : Recognition of the seriously unwell neonate and young infant (rch.org.au)]

54. More broadly, the CPU considered that upon presentation to the MAU, Baby Patel was not appropriately identified as being unwell and requiring urgent medical attention, despite presenting with a range of concerning signs and symptoms as discussed above.

55. The RCA identified that "*there are low numbers of neonatal presentations through MAU, MAU clinicians have limited experience in triaging neonates and use a non-validated neonatal decision aid that is embedded in the triage process. The triage process along with limited clinician experience may have contributed to the delayed escalation of the deteriorating neonate*".

56. The RCA also identified that the MAU is designed for obstetric presentations. The triage process for a neonatal presentation was unclear and may have contributed to delayed escalation.

d) Communication between staff and family

57. When the family presented to the Emergency Department on 4 June 2020, they were told by a non-clinical staff member that there was going to be a '*long wait'*. This prompted the family to take Baby Patel to the MAU. It was not known to the emergency department team that the family were going to the MAU.

58. The RCA identified this communication as a root cause issue, noting that the non-clinical staff member who communicated the wait time was unaware of the clinical situation and triage priorities. In response, the RCA recommended the development of a script for non-clinical staff to use at triage when advising patients of wait times which included a direction to speak with the triage nurse. This update was completed in November 2020 with the script included in the clerical orientation manual and education provided to staff.

59. The family has also identified that there were difficulties in the communication between staff and the family because no interpreter was offered, and Jaykumar was not allowed in the emergency department, presumably because of restrictions imposed due to the COVID-19 pandemic. I understand these concerns were raised directly with the hospital during several family meetings and that in response, Werribee Mercy Hospital determined to display 'REACH out to us' posters in the paediatric waiting area in English and other languages.

e) Communication between staff

60. The lactation consultant appropriately discussed the call with the paediatric team that she received on 4 June 2020 from Jaykumar (regarding the fact that Baby Patel was having difficulty feeding and appeared to be worsening), and gave appropriate advice to the family to present to the Emergency Department immediately for paediatric review.

61. Unfortunately, the lactation consultant did not document this discussion in the medical records until the next day, so the Emergency Department team were not aware that the paediatric team were expecting Baby Patel. There is also no record that the lactation consultant or paediatric team forewarned the Emergency Department about her advice for Baby Patel to present, and to refer for paediatric review. In doing so, this may have reduced the waiting time for this family and prompted earlier medical review.

f) Difficult intubation

62. Baby Patel required multiple attempts at intubation at both Werribee Mercy Hospital and RCH. However, management of these difficulties was reasonable, with appropriate escalation at both sites. The difficulties in intubation were not necessarily due to deficiencies in medical management, but rather due to Baby Patel having a difficult airway.

63. At Werribee Mercy Hospital, the difficult airway was escalated appropriately through the paediatric team, anaesthetic team, and PIPER team. Decision was made to place a laryngeal mask airway for transfer, which adequately supported the airway. At RCH, intubation in the operating theatre, then tracheostomy with the ENT team was the most appropriate and safe choice.

64. The Court was provided with the Werribee Mercy Hospital 'Intubation of a Neonate' policy, dated October 2020. The statement from Dr Kirwan states that this policy was followed for Baby Patel.

g) Paediatric Management

65. The CPU did not identify any concerns regarding the paediatric medical management of Baby Patel with the Werribee, PIPER, and RCH teams. The RCA conducted by Werribee Mercy Hospital identified that *"escalation of the deteriorating neonate was delayed because the paediatrician was already present in MAU with another patient"*.

66. The RCA also identified that a possible delay in the paediatric management was due to the fact that the paediatrician was aware Baby Patel had an unrecordable temperature, but asked for it to be rechecked as it did not fit with the clinical picture.

CPU review of RCA outcomes

67. Following the completion of its review, the hospital undertook a number of updates to its policy and procedures intended to address the root causes identified, including:

    a) Review and update of the Midwifery in the Home Referral Management Procedure;
    b) Updated Emergency Department Triage Procedure to provide that all neonates under 28 days are triaged as a category 2 at minimum, and that the paediatric registrar is to be notified at time of triage. This includes triage process staff education;
    c) Development of a script for non-clinical staff to use at triage when advising patients of wait times;
    d) Updated Maternal Assessment Unit Procedure to reflect neonatal triage process through the Emergency Department; and
    e) The display of 'REACH out to us' posters in the paediatric waiting area in English and other languages.

68. On review of the amended procedures and recommendations, the CPU considered that the amended procedures and recommendations appeared to be comprehensive and appropriate, with the exception of the following two policies:

    a) The MAU procedure; and

    b) The Emergency Department Triage policy.

<u>Midwifery in the Home Referral Management Procedure</u>

69. In response to the administrative error identified which resulted in no follow up appointment being booked, Werribee Mercy Hospital initiated a review of the Midwifery in the Home (**MITH**) Referral Management Procedure. The review included consideration of staff resources, the escalation of care model for neonates vs appropriate visits, the booking process and resourcing, and ensuring there is a validation process to align with the booking of an appointment. The updated policy was completed in September 2020.

70. CPU reviewed the updated policy and did not identify any further opportunities for improvement.

The MAU procedure

71. The RCA identified a root cause of this event as inappropriate triage, limited experience with neonates, low numbers of neonates presenting to the unit, and usage of non-validated decision aid in triage. An additional root cause was that the triage process in the MAU is unclear because the unit is designed for obstetric presentations.

72. The MAU procedure was subsequently amended first in August 2020 and again in April 2024 (**the 2024 MAU policy**). The 2024 MAU policy provides that:

    a) Neonates should be seen in the Emergency Department and are not to be routinely seen in the MAU.
    b) In the event a neonate presents to the MAU, a midwife is to perform an initial assessment.
    c) If emergency/urgent medical review is required, a neonatal code blue should be initiated.

73. The CPU was supportive of these updates. It considered that it is appropriate that all neonates be seen in the Emergency Department, where they will be triaged as Category 2 and seen by the paediatric team.

74. However, the CPU raised concerns regarding an ongoing lack of clarity on the appropriate procedure where a midwife determines following initial assessment that non-urgent medical review is required. On this issue, the 2024 MAU policy reads:

    "If non-urgent medical review is required the mother is advised to take her baby to the Emergency Department or General Practitioner"

75. The CPU commented that in circumstances where the hospital RCA has acknowledged that MAU clinicians have limited experience in triaging neonates, it would be preferable that the policy provide that neonates should be referred to the Emergency Department in all instances. The direction that a MAU clinician may alternatively determine to refer a neonate to a General Practitioner may create a lack of clarity for clinicians and lead to less favourable outcomes, where triage is performed without adequate experience.

The Emergency Triage policy

76. The Emergency Department Triage policy was also amended following Baby Patel's death.

77. The revised policy states that neonates are to be referred *“to paediatrician for early intervention as required”*.

78. The CPU considered that this wording is ambiguous and not in line with Dr Kirwan’s statement which outlined that *“a paediatric registrar is to be phoned when a neonate is triaged so that two teams (ED and paediatrics) can respond”*.

<u>Other considerations</u>

79. With regard to the family’s concerns regarding the lack of an interpreter offered to Alpitaben in the emergency department, the CPU agreed this would have been disempowering and overwhelming and may have contributed to parental concerns not being escalated.

80. The RCA indicated changes were made in response to these concerns, including display of ‘REACH out to us’ posters in the paediatric waiting area in English and other languages on how to escalate concerns in multiple languages.

81. While the display of multilingual posters is a positive development, the CPU noted that this does not directly address the issue of lack of interpreter services offered in the hospital.

82. Additionally, the CPU noted that it was unclear if patient information leaflets covering topics such as ‘When to seek help for you and your baby’ and ‘Recognising serious illness in your baby’ have also been translated into other languages.

FINDINGS AND CONCLUSION

83. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    1. the identity of the deceased was Baby of Alpitaben and Jaykumar Patel, born 27 May 2020;

    2. the death occurred on 6 June 2020 at The Royal Children’s Hospital, 50 Flemington Road, Parkville, Victoria, 3052, from unascertained causes; and

    3. the death occurred in the circumstances described above.

84. Having considered all of the circumstances, I find that there were inadequacies in the care provided to Baby Patel on his presentation to Werribee Mercy Hospital on 4 June 2022. The main issue identified in this case is the lack of recognition at the hospital that Baby Patel was

an unwell neonate, which led to a delay in receiving a medical review in both the emergency department and the Maternity Assessment Unit.

85. However, noting the cause of death is unascertained, it is unable to be determined whether a more timely review would have altered the outcome.

86. I acknowledge the concessions made by Werribee Mercy Hospital in this regard and commend them on efforts to improve practices following Baby Patel's death, including through updating relevant policies, implementing a script for non-clinical staff to use at triage when advising patient of wait times, and developing improved patient information pamphlets and posters.

87. While these are positive developments, I am of the view that there are opportunities for further improvement, and have made comments below in this regard.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Education for Triage Staff

1. In view of the inaccurate triaging of Baby Patel, and subsequent delay in review within the Emergency Department, I consider that additional education for triage staff is warranted, particularly with regards to neonatal assessment, including recognition of an unwell neonate.

2. Mercy Health has indicated in response to draft findings that it is open to facilitating such training and education for Emergency Department triage staff.

Clarification of MAU Policy for neonatal presentations

3. While the CPU was generally supportive of updates included in the 2024 MAU policy, it considered that the policy could be further clarified by removing ongoing uncertainty regarding appropriate steps to be taken where a neonate is assessed as requiring non-urgent medical review. The CPU considered that it would be preferable if neonates are referred to the Emergency Department in all instances. If the intention is for neonates not to be assessed or provided with care at all in the MAU, this should be explicitly stated in the policy, with their care being then redirected to the Emergency Department.

4. In response to being notified of CPU's concerns, Mercy Health has indicated that it accepts the CPU's comments and will amend its MAU policy to read as follows:

> *"If non-urgent medical review is required, the baby is referred directly to the Emergency Department."*

5. Mercy Health further noted that Werribee Mercy Health Emergency Department now has a dedicated paediatric space, open for morning and evening shifts, which will operationally support neonates being referred to ED from the MAU.

Process for escalation of parents/carer concerns

6. In considering any further updates to its policies, Werribee Mercy Hospital may also have regard to the recent coronial recommendation in the finding into the death of Noah Souvatzis that consideration be given to incorporating a question to be asked by clinicians about parental and carer concerns as a core vital sign in paediatric patients.[18]

7. In its response, Mercy Health indicated that it considers it reasonable to include parental concern as a vital sign in assessment of paediatric patients and that it is currently considering how best to implement this approach in practice.

Clarification of Triage Policy in ED for neonatal presentations

8. The current wording of the triage policy for neonates is ambiguous. A clearer triage policy should be in line with the Root Cause Analysis recommendations, in that the paediatric team must be called from triage when a neonate presents.

9. Mercy Health has indicated that it considers it reasonable to update the ED Triage Procedure to address the assessment and management of neonates in the ED and clearly state that a paediatric registrar is to be phoned when a neonate is triaged so that both the ED and paediatric team can respond.

Cultural Sensitivity

10. Pamphlets and leaflets provided to families following birth should be published in multiple languages.

11. In response, Mercy Health has indicated that it considers this comment reasonable and will take steps to translate patient information leaflets including topics such as 'When to seek help

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[18] Findings into the death of Noah Andrew Souvatzis dated 6 August 2024, accessible on the Coroners Court of Victoria website at https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202021%20007004%20Form%2037-Finding%20into%20Death%20Following%20Inquest_Signed.pdf.

for you and your baby' and 'Recognising serious illness in your baby' into other languages that are in alignment with the Werribee Mercy Hospital population demographics and the other patient information it has translated.

I convey my sincere condolences to Baby Patel's parents, and their friends and family for their loss.

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

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

Jaykumar & Alpitaben Patel, Senior Next of Kin

Mercy Health via HWL Ebsworth

Royal Children's Hospital

Senior Constable Samuel Ho, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date : 02 December 2024

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.