IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005070

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Katherine Lorenz
Deceased:	Siya Yogin Patel
Date of birth:	20 August 2020
Date of death:	12 September 2020
Cause of death:	1(a) hyperviscosity-related brain injury secondary to hypernatraemic dehydration
Place of death:	14 Dutch Avenue, Wyndham Vale, Victoria, 3024
Keywords:	Medicare ineligible, neonate, newborn assessments, dehydration, insufficient feeding, telehealth, Maternal and Child Health services

TABLE OF CONTENTS

INTRODUCTION

1. Siya Patel was a 23-day old baby girl who died at home on 12 September 2020 from a brain injury caused by dehydration from insufficient oral intake.

2. Siya was the first child to her parents, Chaitali and Yoginkumar Patel (both aged 29 years at the time of her death), who had emigrated to Australia in 2017. The family lived with Siya's maternal uncle, his wife, and their child. Siya's paternal grandparents were due to travel to Melbourne to support the family after the birth. However, due to COVID-19 related travel restrictions, this was unable to occur.

3. The family did not have access to Medicare but had "international visitor" private health insurance. This cover did not include some of the standard and otherwise fully Medicare funded outpatient post-natal reviews.

4. As such, there were out of pocket costs for Siya's parents to receive equivalent "free" care afforded to Medicare eligible families. This led to an unconventional post-natal review pathway which involved clinicians who do not perform these kinds of assessments regularly. Siya's postnatal care was also affected by the COVID-19 pandemic.

5. The culmination of these two key factors meant that Siya's parents were insufficiently supported as new parents and Siya's insufficient intake went unnoticed. Siya's death was entirely preventable.

THE CORONIAL INVESTIGATION

6. Siya'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.

7. 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.

8. 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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Siya's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

10. The Court sought additional statements directly from the Department of Health, the local council responsible for Maternal and Child Health Services for Siya, the GP clinic, and the hospital.

11. This finding draws on the totality of the coronial investigation into the death of Siya Yogin 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.[1]

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

Circumstances in which the death occurred

Antenatal Care

12. Siya's mother had a planned and uneventful pregnancy and was referred to Werribee Mercy Hospital (**WMH**) for antenatal care. The Patient Liaison Officer (**PLO**) was notified, and on 1 March 2020, a face-to-face finance meeting occurred to detail fees and present the Informed Financial Consent, Election for Admission and Private Health Insurance forms for signing.

13. In this meeting, it was confirmed that the family's private insurance would fully insure the hospital inpatient stay. The family was informed that outpatient antenatal appointments and MITH (**Mercy in the Home**) home visits were required to be paid in full. However, a partial rebate may be payable if the invoice was submitted to the private insurer.

[1] 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.

14. As there was a cost associated with outpatient antenatal visits, the family opted to change to a "Shared Care" model, with a shared care antenatal care arrangement between WMH and the General Practitioner (**GP**) at Hoppers Lane General Practice (**Hoppers Lane**).

Hospital Delivery

15. On 20 August 2020, Siya's mother went into spontaneous labour. Siya was born at 38 weeks and 6 days gestation at WMH via emergency caesarean section due to failure to progress. Siya's birthweight was 3.69kg and she was born in good condition. Siya did not require any resuscitation or admission to the special care nursery nor were there any postnatal concerns noted. Breastfeeding was commenced on day 1 of life; initially Siya did not suck well, and she required expressed milk via syringe.

16. On 21 August 2020, the family was requesting early discharge as they were concerned about the costs of remaining in hospital. The PLO advised the family that they were fully covered for the inpatient admission. The family agreed to stay that night and gave consent for a MITH home visit.

17. By the second day of life, it was noted that breastfeeding was establishing well, and Siya's mother was confidently feeding Siya. Urine and meconium had been passed appropriately. Siya had a paediatrician review to review a small lump on her head, which was confirmed as being inconsequential, with no other concerns noted by the paediatrician.

18. On 22 August 2020, Siya and her family were discharged. Siya's weight at discharge was 3.57kg, which is about a 3% loss of birthweight. Up to 10% weight loss in the first few days of life is considered acceptable, and neonates are expected to regain their birthweight by 10-14 days of life.

19. As the family had confirmed with their private health insurance provider that they would not be covered for MITH, they indicated a preference to go to their GP for subsequent newborn review. The follow up review was planned to be with the family's GP in 2-3 days.

20. On 23 August 2020, a WMH midwife contacted the local Maternal and Child Health (**MCH**) service, which was Wyndham City Council (**WCC**), to notify them that the patient had been discharged without routine domiciliary midwife home care services through MITH.

First GP Review

21. On 24 August 2020, Siya had her first postnatal review at Hoppers Lane. This appointment was booked under Siya's mother name as Siya had not yet been registered as a patient at the practice. Documentation for this consultation therefore occurred in Siya's mother's file rather than Siya's file.

22. The GP reviewed both Siya and her mother. The contemporaneous consultation notes for this visit are limited. The reason for visit and diagnosis was oral thrush, and a prescription for thrush treatment was provided. More comprehensive notes were entered by the GP on 11 September 2020.

23. In these retrospective notes, as well as in their statement, the GP stated that when they examined Siya, she appeared to be a happy and well appearing baby, with normal vital signs and no abnormal findings on examination apart from oral thrush.

24. These retrospective notes also outlined Siya's mother's recovery from the birth and feeding. It was noted that Siya's mother was confident with feeding, and it seemed that she had enough breast milk as she still had milk available after expressing. Siya was reportedly feeding and sleeping well. The GP could not recall the exact number of reported wet nappies but recalled that it was a normal number. Apart, from treatment for oral thrush, no other intervention was recommended at that time. Siya's mother did not raise any concerns or questions.

25. In their statement, the GP outlined that after they reviewed Siya, Siya's mother requested that Siya be weighed. The GP directed the family to the treatment room where a practice nurse could weigh Siya.

26. The practice nurse weighed Siya and recorded her weight of 3.27kg in her "Green Book".[2] The weight was not recorded in the patient file as Siya did not yet have one. Siya's weight was 11% below birthweight. A neonate who has lost more than 10% of birthweight should be evaluated by a medical professional with a complete feeding assessment, lactation support, and other interventions and investigations as necessary. However, this did not occur.

27. According to Siya's parents, the practice nurse appeared happy with the weight and made comments to the effect of: *"it's just 10% [loss]…it's just normal"* and did not give advice about feeding strategies or suggest re-weighing Siya in the coming days. After being weighed,

[2] Colloquially named after its appearance, the Green Book, or The *My Health, Learning and Development* book is given to the parents of every newborn child in Victoria. It contains information about early childhood development and services and is often kept as a record of a child's health, growth, development, immunisations, and other milestones throughout childhood.

the GP was not informed of the result nor did they request to review Siya again after being weighed, and the family went home.

MCH Review

28. From 22 to 30 August 2020, no further nursing or medical reviews were conducted. Siya's parents spoke with overseas relatives about Siya's sleep, and they were reassured when told it was normal. They did not discuss her feeding or weight with these relatives.

29. After receipt of Siya's birth notice, an Enrolment Visit appointment with the WCC MCH service was made. The Victorian MCH service is a free universal primary health service—Medicare is not required to access this service and there are no out-of-pocket charges for Medicare ineligible families.

30. On 31 August 2020, the initial visit was performed by a WCC MCH Nurse (**MCHN**). The consult was performed via video telehealth due to limitations on home visits due to the COVID 19 pandemic related Stage 4 restrictions. However, as the MCHN had difficulties utilizing the video software, the consult was conducted over telephone.

31. Prior to the pandemic related restrictions, the Enrolment Visit would either involve the MCHN visiting a family at home or an appointment at the local MCH centre.

32. It was reported that Siya was doing well with feeding, but her sleeping had decreased from 2-3 hours between feeds, to 5-10 minutes at a time. Through active questioning, Siya's mother stated she had no concerns about breastfeeding, nor specific concerns about Siya. As a result, the MCHN made no counselling or other referrals.

33. Siya's mother told the MCHN that Siya had been weighed at her GP two days after discharge but was unable to provide the weight measurement as she could not find the Green Book. She stated she thought it started with "33…" but wondered if the scales were accurate.

34. The MCHN assessed Siya by asking questions about her appearance and behaviour. Siya's mother responded that Siya was "lovely and strong", she had a "lusty cry", and that she was alert and calm. Siya's mother described the colour of stools as yellow, and stated that nappies were always wet before feeds.

35. The MCHN described jaundice and asked if the baby was showing any signs of jaundice, which Siya's mother denied. At the end of the consultation, the appointment schedule that had

been made by the MCH Administration team was communicated to Siya's mother, with a face-to-face appointment with another MCHN scheduled for around one week later.

Second GP Review

36. From discharge from WMH until 1 September, Siya was solely breastfed for 30 minutes on alternate breasts every 2-3 hours, including overnight. The family thought Siya was latching and sucking well and was receiving the same volume of breast milk each feed. It was reported that Siya only cried occasionally, either in her sleep or during nappy changes, and she never demanded feeds.

37. On 1 September 2020, Siya's feeding appeared to decrease with up to 8 hours between feeds and decreased wet nappies.

38. On 2 September, Siya was weighed at home and was 2.6kg (over 1kg below birthweight). There had been one lightly wet nappy in the past 24 hours and two bowel movements. Siya was given a 10ml formula top up feed and called the MCH helpline. The advice was that Siya needed urgent medical review, and the family presented to their local GP practice.

39. Siya was reviewed by a different GP as the family's regular GP was unavailable. Siya's weight was 2.8kg and appeared dehydrated. The GP recommended that Siya be taken to hospital immediately for urgent review.

Admission to RCH

40. The same day, Siya presented to Royal Children's Hospital (**RCH**) Emergency Department (**ED**). On examination, she appeared unwell, encephalopathic, and had an abnormal cry. She was hypothermic and apnoeic with decreased skin turgor and a delayed capillary refill time of 5-6 seconds. Siya weighed at 2.69kg, which was 1kg below birthweight.

41. Intravenous (**IV**) access was obtained, and Siya received fluid resuscitation and antibiotics. Investigations showed an extremely elevated blood sodium level of 194 mmol/L.[3] Despite medications and other initial interventions for respiratory support, Siya required intubation and ventilation.

42. Siya was admitted to the Neonatal Intensive Care Unit (**NICU**) under the Neonatal team. Multiple subspeciality teams were consulted to investigate and advise on possible causes of

[3] Normal levels are between 135-145mmol/L.

Siya's hypernatremia (high sodium) and dehydration, as well as provide support for Siya's complications, such as seizures and acute renal failure.

43. These teams included:

    a) Endocrinology – who gave an opinion of severe dehydration with hypovolemic hypernatremia rather than some other underlying cause.

    b) Nephrology – who managed Siya's acute kidney failure, fluid management, peritoneal dialysis, and consideration of causes of her clinical picture.

    c) Urology – who performed the peritoneal dialysis catheter insertion.

    d) Neurology – who interpreted EEG and MRI brain scan results in the setting of ongoing seizures and gave advice regarding seizure medication. The EEG showed a mildly encephalopathic picture and the MRI showed a typical pattern of hyperviscosity-related cerebral injury.

    e) Metabolic medicine – who gave an opinion that Siya's condition was unlikely be due to a primary metabolic condition. However, Siya was still screened for various metabolic conditions.

    f) Genetics – who gave an opinion that it was unlikely that there was an underlying genetic cause for presentation, and Siya had a normal molecular karyotype.

    g) Haematology – who gave an opinion that a combination of severe dehydration and the consequent metabolic derangement would potentially cause the blood to become quite viscous and clot.

44. Overall, investigations and specialty consultations did not suggest an alternative cause for Siya's condition. The consensus was that hypovolemia (low blood volume), biochemical abnormalities, and hyperviscous blood resulted in significant brain and renal injuries.

45. Over the next five days, Siya was managed with peritoneal dialysis and careful fluid and electrolyte management. She also required multiple doses of anticonvulsants for recurrent seizures.

46. Siya's mother commenced expressing breastmilk during Siya's hospital stay which was measured to be 20-30mL every three hours. Siya's expected intake to maintain hydration

should be between 50-75mL every three hours. Clinicians concluded that the amount of breastmilk that Siya's mother was producing was not adequate for Siya's growth or hydration.

47. On 8 September 2020, an MRI brain was performed which showed multifocal haemorrhage (bleeding) throughout the parenchymal white matter and a severe injury to the left posterior limb of the internal capsule. This was reported to be *"consistent with a hyperviscosity related brain injury"*. In other words, Siya's blood had become so thick from dehydration that it was causing damage to her brain and other organs.

48. Discussions with Siya's parents regarding her likely poor neurodevelopmental outcome led to a decision to redirect intensive care to a palliative pathway.

49. On 11 September 2020, and at the family's request, Siya was transferred home under the care of local palliative care services.

50. On 12 September 2020, Siya died peacefully at home in her mother's arms.

Identity of the deceased

51. On 12 September 2020, Siya Yogin Patel, born 20 August 2020, was visually identified by her father, who completed a statement of identification.

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

Medical cause of death

53. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 14 September 2020 and provided a written report of the findings.

54. Dr Parsons commented that autopsy findings were in keeping with the clinical history from RCH and were highly suggestive of malnutrition. Dr Parsons noted that rare genetic or metabolic causes cannot be entirely excluded and recommended for Siya's parents to undertake prenatal counselling prior to any future pregnancies.

55. Dr Parsons provided an opinion that the medical cause of death was *1(a) hyperviscosity-related brain injury secondary to hypernatraemic dehydration* and was due to natural causes.

56. I accept Dr Parson's opinion.

FAMILY CONCERNS

57. Siya's mother stated:

"I believe that the hospital gave us good advice and support and we went home with Siya feeling confident and prepared. However, being first time parents, we don't know everything and due to COVID, the first appointment with the maternal health care nurse was over the phone, this should have been a face-to face appointment.

"I feel like the circumstances in place because of COVID meant that the support I received was less than it should have been. I spent most of my time at the hospital alone, trying to recover from a c-section and look after my very first newborn baby all by myself."

ISSUES

58. During Siya's admission to RCH, a Consultant Neonatologist referred Siya to the Victorian Forensic Paediatric Medical Service (**VFPMS**). A paediatrician from the VFPMS examined Siya, reviewed the various medical records, and consulted with a wide range of medical specialists to produce a report dated 21 October 2020.

59. The report identified several issues with Siya's care as described below. The underlying contributing factors were:

    a) a lack of communication between health services and individual providers;

    b) COVID-19 pandemic related health service delivery changes;

    c) a lack of identification of a vulnerable family; and,

    d) a lack of access to Medicare services.

VFPMS Review

60. The VFPMS paediatrician provided an opinion that:

"Siya was extremely unwell on presentation and was intubated, resuscitated and admitted to the Neonatal Intensive Care Unit. Numerous investigations revealed the extend of Siya's biochemical and metabolic derangement, but investigations and speciality consultations did not suggest an alternative cause for her condition.

"It was generally agreed that hypovolaemia (low blood volume), biochemical abnormalities and hyperviscous blood resulted in her significant brain and renal insults."

61. The VFPMS paediatrician outlined several issues which may have contributed to her illness. These included:

    a) A lack of access to Medicare.

    b) Siya's 11% weight loss (from birth weight) was recognised but not acted on.

    c) The COVID-19 pandemic prevented Siya's paternal grandparents from travelling to Melbourne to live with Siya and her parents.

    d) The initial MCHN home visit was conducted by telehealth with no video.

Communication between health services and providers

62. A breakdown in communication between health care providers at multiple levels was a significant contributing factor.

63. The first breakdown in communication occurred from WMH as the discharging maternity hospital. A discharge summary was compiled which included the fact that domiciliary midwife services had been declined and Siya was to see her GP in 2-3 days for a weight check.

64. The statement from WMH indicated that this discharge summary was sent to the GP. However, in the GP stated that this was not received. The local MCH also reported that they did not receive the discharge summary nor receive any communication from the hospital that Siya did not have domiciliary midwife follow up.

65. However, this contradicts the WMH medical records which document that on Siya's discharge, that a phone call was made from a WMH midwife to inform the MCH service to advise of Siya's discharge and lack of domiciliary nurse review. Regardless, the MCH service guidelines state that the Child Health Record (**CHR**) hospital discharge summary should be checked on the initial enrolment visit, and this was not done.

66. As a result of the multiple communication breakdowns, two key pieces of information, namely the lack of domicillary midwife visit and the need to perform a weight check, were not known by the attending GP nor MCHN.

67. Further breakdowns in communication also occurred at the GP clinic. The GP did not explicitly communicate the request for Siya to be weighed to the practice nurse, and the practice nurse did not relay the results back to the GP. The GP did not communicate with the MCH about Siya's presentation.

68. Finally, there was likely a lack of communication from the MCH service to the wider health network, as the GP clinic was not aware that most MCHN visits were being conducted via telehealth at that time.

COVID-19 pandemic related health service delivery changes

69. Siya was born during the Stage 4 lockdown restrictions during the COVID pandemic in 2020. During this time, health services were required to rapidly adapt to government directives with regards to care provision and limitations in the interest of public safety.

70. However, by the time of Siya's birth, The Department of Health and Human Services (**DHHS**)[4] directed for young infants (aged 0-8 weeks) to be prioritized for face-to-face MCH consultations. Despite this directive, Wyndham MCH service did not conduct face-to-face consultations for most young infant visits until October 2020, reportedly due to staff shortages and Wyndham MCH service constraints. Siya's initial enrolment visit was conducted via telehealth, as were the vast majority of Enrolment Visits in Wyndham city in August 2020.

71. An additional contributing factor was the fact that this visit occurred via telephone (without video), due to inadequate infrastructure to support MCH staff to use telehealth platforms from their homes.

72. A major limitation of telehealth (and particularly telephone) is the total reliance on patients or caregivers for accurate information as physical examination is not possible. Even if questions are adapted in a simplified format, the observations and responses from inexperienced first-time parents, may differ from a trained midwife or nurse.

73. As such, it is entirely plausible, and indeed likely, that even though the responses from Siya's parents during the MCH enrolment visit on 31 August 2020 did not raise concerns about Siya's

[44] Following machinery of government changes, DHHS split into the Department of Health and the Department of Families, Fairness and Housing in February 2021. "DHHS" and "Department of Health" are interchangeable for the purposes of this finding, but I have referred to each according to the temporal context.

feeding or breast milk supply, an MCH conducting a home review might have reached a different conclusion.

74. The Australian Health Practitioner Regulation Agency (**AHPRA**) guidelines for the use of telehealth state that a practitioner performing telehealth should:

"Assess (and regularly re-assess) whether telehealth is safe and clinically appropriate for the patient or client, particularly noting the limitations of telehealth, and whether a direct physical examination is necessary to provide good care.

"Ensure that you do not attempt to provide a service which puts patient or client health or safety at risk.

"If, because of the limits of technology, you are unable to provide a service to the same standard as an in-person consultation then you must advise the patient or client of this."[5]

75. In Siya's case, a telehealth consultation was not clinically appropriate, as a physical examination and observation was necessary to provide adequate care. The use of telehealth meant the service provided to the family was not to the same standard as an in-person Aconsultation. This use of telehealth without an accompanying face-to-face review contributed to the lack of early detection of Siya's poor feeding and dehydration.

Lack of identification of a vulnerable infant and family

76. Siya was a vulnerable infant, born to first time parents who had recently emigrated and had limited support networks in Australia.

77. The MCH Service guidelines state that *"[c]hildren and young people are vulnerable if the capacity of parents and family to effectively care, protect and provide for their long term development and wellbeing is limited."*

78. On vulnerable families generally:

"The family may be at risk of adverse health and wellbeing outcomes due to individual, parental or family experience or circumstances."

[5] Available at <https://www.ahpra.gov.au/documents/default.aspx?record=WD20%2F29680&dbid=AP&chksum=kaxl7ebGeeWAvIEoklLLLw%3D%3D>

79. By this guideline, Siya would have met criteria for a vulnerable child in the context of a vulnerable family. As relatively unsupported first-time parents, Siya's parents did not recognize the seriousness of her condition until she was critically unwell. Siya was involved with three health services prior to her admission to RCH and none of them identified her as being a vulnerable infant.

80. This lack of recognition of her vulnerability meant that appropriate supports and follow up were not put into place, which contributed to her death. The lack of face-to-face follow up also contributed to Siya's vulnerability which was also not appreciated.

ORGANISATION RESPONSES

81. Across the various correspondence with the Court, it became apparent that many of these issues were also recognised by each of the organisations involved in Siya's care. The reviews performed by each organisation with the relevant findings, recommendations, and implementation of those recommendations are also outlined in this section.

Werribee Mercy Hospital

82. Mercy Health outlined the process for admission and discharge of international patients without Medicare cover at WMH:

"The process for admission of international patients without Medicare at [WMH] is to connect the families with the [PLO]. The PLO will ensure that interpreters are provided, and the Mercy Hospital schedule of fees is explained to the families. A fund eligibility check is performed if private health cover is available and cost implications are discussed with families. A detailed informed financial consent form outlines all relevant treatment costs, consultation and visits costs. The informed financial consent is signed after the PLO is satisfied that international patients have understood the requirements.

"Post Natal discharge services offered to international patients without Medicare at WMH are:

- *Patients are offered the fee for service Werribee Mercy [MITH]. If the patient declines this option, visits may be provided free of charge if financial hardship is established. Patients may also return to the hospital for review. If a woman cannot afford the MITH visit, this is escalated to the Nursing Unit Manager to authorise a non-chargeable visit.*

- *Patients who decline MITH are referred their GP for follow up services and to Maternal Child Health services.*

"Our current fee for MITH Services is $310 per visit. At the time of the birth of Siya Patel, the fee was $290.00.

83. Mercy Health performed an internal review of the case and identified that:

a) Private health insurance policies are variable in the inclusion of MITH visits.

b) MITH visits were not fully covered by the patient's private health insurance policy.

c) The out-of-pocket gap led the patient to elect not to have MITH visits.

d) A GP visit is less expensive than the costs of a MITH visit for a patient who is Medicare Ineligible and whose private cover does not cover MITH visits.

84. Mercy Health provided an attachment outlining the outcomes of the recommendations from the review, as well as the associated policies *"Financial Hardship for Patients without Medicare Procedure"* and *"When to seek help for you and your baby"* patient information sheet.

85. These have since been fully implemented and, importantly, the first MITH visit has now been incorporated into a single upfront fee for the entire continuum of care at WMH. If there are any concerns, patients will receive subsequent MITH services without cost. Further, discounts and payment plans can be offered if fees are not fully waived.

Hoppers Lane General Practice

86. The practice nurse acknowledged that they should have asked the GP why Siya was being weighed, reported the outcome to the GP, and ensured that Siya saw the GP after being weighed. These concessions are acknowledged and commended.

87. However, the practice nurse should not have been put in this position in the first place, nor should they have been required to make a clinical judgement about Siya's weight. The GP clinic should have had clear policies and guidelines to follow outlining the processes for patient workflow and neonatal measurements. It should have been a matter of course for Siya to be reviewed again by the GP with her growth measurements.

88. GP assessments do not usually occur until 6 weeks of age. This 6-week check is a relatively standardised assessment and will often coincide with scheduled immunisations. The GP noted that a follow up assessment is normally performed in the community by a MCHN at 2 weeks of age. The relative unfamiliarity with these kinds of assessments without a clear process likely contributed to the various miscommunications within the clinic.

89. Siya's case was reviewed at a staff meeting on 18 December 2020 and has been the subject of ongoing formal and informal discussions. Changes to practice include:

    a) Medical practitioners are required to provide direct instructions to nursing staff as to what treatment is required. If a patient presents directly to the treatment room without nursing staff having been advised of planned treatment, the treating medical practitioner is contacted for instructions.

    b) Medical and health practitioners have been reminded of their responsibility to ensure that a file is created for each patient seen in the practice and that each patient presenting to the treatment room is required to have, and bring with them, a clinic file.

    c) All patients seen in the treatment room are to have their visit recorded in their patient records. A new patient record should be created if they do not already have one;

    d) Patients and accompanying family members are required to return to the treatment medical practitioner following treatment for further advice.

    e) Babies under 3 months of age are to be seen in the treatment room prior to consultation with the medical practitioner for weighing and measuring. This information is documented in both the Green Book and patient file.

90. The GP who saw Siya first after discharge from WMH also outlined changes to their personal practice:

    a) The GP informs pregnant patients who present as part of shared maternity care that if the MCHN is unavailable to review at 2 weeks of age, or there are any parental concerns with the MCHN review, then parents should bring the newborn in for review.

    b) If a baby is brought in without a hospital discharge summary, then the GP will call the hospital directly or otherwise source the discharge summary.

c) If an appointment is made under a parent's name, the GP requests that the parent see reception to set up a patient file for the newborn.

d) The GP requests for growth measurements to be verbally handed over from the nurse after they have been taken.

Wyndham City Council Maternal and Child Health Services

91. Siya's case was reviewed in the context of a wider Wyndham MCH Service review of the whole MCH service operation throughout the pandemic in 2020. This review included a specific focus on the circumstances of Siya's death.

92. The review noted that Siya's enrolment visit occurred on day 11 of life, within the expected time frame for this to occur. She was then scheduled for face-to-face appointment at ages 2, 4 and 8 weeks. However, this did not occur as she was admitted to hospital and died prior to these dates.

93. The review noted that the enrolment consultation went for an hour and covered the expected areas to be assessed, adapted as necessary due to the non-face-to-face context with the nurse asking questions of the parents to gain the necessary information.

94. The review found that it was not reported to the MCH service that Siya's parents had introduced formula feeding or top ups. Questions regarding health and development, feeding and safety did not indicate an additional appointment was required prior to the face-to-face consult that was booked for the following week, where a physical examination would occur. The nurse did not note any clinical or social concerns which would have prompted an enhanced care referral or immediate physical examination.

95. The review highlighted that this first appointment would **not** normally include a physical examination of the infant as per DHHS MCH practice guidelines. These guidelines have since been updated and the first home visit now has a physical assessment component with weight check.

96. The review found that the Wyndham MCH service was not aware that a domiciliary visit had not been conducted for Siya. The MCH nurse was made aware that Siya's family had sought post-discharge care and follow up from a GP because they did not have access to Medicare. Wyndham MCH case notes do not indicate that there was any communication from the GP or hospital with the MCH service. While Siya's mother stated that she felt the scales at the clinic

may not have been accurate, she did not report that the GP raised any concerns about the growth and development (including weight) of the baby at the time of the enrolment visit conducted by telephone.

97. The review did not find that any action or decision in the Wyndham MCH service contributed to or was causal to the death of Siya. I wholly reject this finding because I consider that had a face-to-face appointment occurred as directed to be prioritised by DHHS, then it is likely that Siya's poor feeding would have been recognised and acted on. Further, the omission of a weight check at this visit contributed to the lack of recognition that Siya was unwell.

98. However, and as outlined below by the Department of Health, I note that this practice has since changed, and that all babies at an Enrolment Visit are physically examined and weighed.

99. Nonetheless, the review recognised several issues and made several recommendations. These were broadly regarding service provision, telehealth, communication with other health services, and recognition of vulnerable infants.

Service provision

100. Siya did not receive a MCHN home visit as her initial consultation prior to the 2-week consultation, despite DHHS directives to supplement telehealth consultations with face-to-face consultations for this age group. This was primarily because of workforce pressures and shortages. These shortages have since been improved but remain an issue.

101. Siya's subsequent 2-week review had been scheduled as a centre based face-to-face appointment. It was noted that the nurse conducting the enrolment visit could have invited the family in for an additional face-to-face visit, but the description by the family did not raise alarm and the infant had face-to-face appointment booked with the service for the following week.

102. The review recommended to strengthen the recognition and risk assessment of the critical neonatal period of life in the prioritisation of service impacting decisions across the organization, and the elevation of the prioritisation of the MCH DHHS team information requests under any State of Emergency that impacts infant care. It was also recommended to review of the impact of Medicare ineligibility on accessing critical services and associated risks to infants and their families.

Digital and telephone services – telehealth and communications

103. A copy of the October 2020 DHHS rapid review of "Telehealth in the Maternal Child Health Universal program during COVID-19" was referenced as part of the internal review.

104. In the context of Siya's case, the model of telehealth adopted is not appropriate for all aspects of MCH care. For the information provision components of these reviews, telehealth is appropriate. However, it is less appropriate for the physical assessment components. This includes engagement of first-time parents, home visits through to 8 weeks, very young babies from birth-4 months, and families experiencing vulnerability, including anxiety about being unable to have their child assessed through a face-to-face visit.

105. It was recommended that during the COVID-19 pandemic, face-to-face delivery is strongly recommended rather than telehealth delivery for these categories. If face-to-face delivery is not an option for MCH services, video or a combination of video and telephone is superior and recommended over consultation by telephone alone.

106. Other recommendations included dedicated and tailored training for staff who require additional support in using a new system with a dedicated virtual team member to assist and troubleshoot any potential issues with the system. Additional measures included providing an option for staff to work from a Council site where internet access is poor at their home address or when home was not a safe environment for the staff member.

Communication with other service providers (lack of electronic discharge summaries)

107. The review noted that discharge summaries would normally be presented by parents at their first contact, usually in the home. However, this presents risks in missing information or communications. Following the transition of MCH services to online and telephone consultations rather than home and centre based face-to-face visits, many discharge summaries were not able to be reviewed by MCH nurses.

108. In Siya's case, a hospital discharge summary was not received by Wyndham MCH service. This would have shown that hospital midwifery did not provide domiciliary services and would have triggered earlier contact by Wyndham MCH. The review identified that the lack of communication of clinical information from the hospital is of concern and may place infants, mothers, and potentially, nurses at risk.

109. The review identified that DHHS process improvements are required to enable easy access to electronic discharge summaries by early care providers. This should occur regardless of

pandemic conditions and would be a modernisation of the current process with improved risk management and triaging by the service.

Identification and prioritization of vulnerable infants

110. Siya could have had had access to an Enhanced Maternal Child Health program. This service is designed to respond assertively to the needs of children, mothers and families at risk of poor outcomes. It provides a more intensive level of support to those with additional needs, in the form of targeted actions and interventions.

111. Siya was not identified as requiring this service and was not referred.

Department of Health

112. The Department of Health (**the Department**) provided helpful background on MCH services and newborn services generally as well as addressing some of the issues in this case.

Discharge summaries

113. The Department clarified that all public health services providing maternity care are required to provide electronic referral to MCH as a part of discharge planning. This should include a discharge summary which outlines the relevant history, medications, postnatal care plan, and the reason for referral. It was noted that new parents are routinely provided a hard copy discharge summary attached the Green Book for provision to the MCHN at the first home visit.

114. The Department also advised that, anecdotally, many health services were unable to distribute electronic discharge summaries to the relevant MCH service. The Department indicated that they would continue to monitor this.

MCH workforce shortages

115. The Department advised that workforce shortages affecting the MCH service are ongoing and full MCH service delivery is not being provided. However, full service delivery is being provided for infants aged 0-8 months, the workforce deficit is significantly reduced, and Wyndham MCH are close to returning to full universal MCH service delivery for all age groups.

Content of the first home visit

116. The Department reiterated that the provision of telehealth for babies like Siya were required to be supplemented by short face-to-face MCH consultations for weight checks, physical examination, breastfeeding support, and developmental checks.

117. The Department stated that a face-to-face home visit through domiciliary midwife or community based MCHN together with an assessment of nutrition and weight check would likely have identified any continuing weight loss and the need for further intervention.

118. The Department confirmed that the MCH service practice guidelines have been updated to make it clear that all infants are weighed at the first home visit. If telehealth is used in exceptional circumstances, then an additional face-to-face appointment is required to complete a physical assessment, including weight measurement.

Medicare ineligible presentations

119. The Department provided statistics on the number of Medicare ineligible paediatric presentations to Emergency Departments and hospital separations from 1 July 2016 to 30 June 2023. These have remained stable over this period and approximately 2% of neonatal (0 to 28 days of age) hospital separations are Medicare ineligible.

Increase in similar cases of malnutrition

120. Finally, the Department advised that there has been an increase in deaths in the 0–4-year age range from malnutrition and its complications. These deaths occurred within vulnerable and marginalised families who were either minimally or not at all engaged with MCHN services and general practitioners. The limited face-to-face consultations with primary care providers and a lack of recorded weight and growth monitoring resulted in these children suffering unrecognised severe malnutrition.

121. These findings with subsequent recommendations are published in the *Victoria's Mothers, Babies and Children 2021 Report.*[6] This report was produced by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (**CCOPMM**).[7]

122. The contributing factors in the deaths of these infants and children included:

[6] Available at <https://www.safercare.vic.gov.au/reports-and-publications/victorias-mothers-babies-and-children-2021-report-and-presentations>

[7] CCOPMM is a statutory committee appointed by the Minister for Health. Its role is to monitor and provide advice to the Minister for Health, Safer Care Victoria, and the Department on maternal, perinatal, paediatric mortality and morbidity, to improve health outcomes.

a) A lack of antenatal or postnatal care in neonates.

b) A lack of recognition of the seriousness of the condition by parents or caregivers.

c) A delay in care seeking.

d) A lack of recognition of the treating practitioners to recognise the severity of the issue and investigate failure to thrive.

e) Difficulty accessing in-person medical or MCH services due to COVID-19 restrictions, staffing capacity and conversion to telehealth.

f) Parental and family factors of intellectual disability, pervasive developmental disorders, mental health issues, substance abuse, family violence, and poverty.

g) Inability to access medical care due to poverty and social issues.

h) Lack of access to Medicare-funded services.

123. The Department highlighted the following areas for improvement:

a) In-person appointments – telehealth consultations are a barrier to recognising failure to thrive and/or severe malnutrition because physical observations and growth monitoring cannot be adequately completed.

b) Awareness of the complications of syringe feeding babies – although widespread, it potentially clouds recognition of a baby's incapacity to suck feed, which needs to be considered when there are growth concerns.

c) Diagnosis awareness – in a highly developed country, the diagnosis of malnutrition is less considered than other causes of poor growth.

d) Strengthening the transition of care from maternity to maternal and child health services.

e) Strengthening the flagging tool for maternal and child health nurses and general practitioners that identify vulnerable families and prioritises them for appointments and follow-up if they fail to attend booked appointments.

f) Referral to Child Protection if families disengage with services and there is a risk of malnutrition that can result in morbidity and mortality.

g) Community service agencies involved following a Child Protection referral should ensure there is support for families to remain engaged. If they disengage, then referral back to Child Protection is necessary.

124. Finally, the Department noted that across all types of deaths and all age groups, CCOPMM continues to observe an overrepresentation of children from vulnerable families. CCOPMM is concerned that the recent increase in economic pressures on families will worsen this problem.

125. I share CCOPMM's concern.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Siya Yogin Patel, born 20 August 2020;
b) the death occurred on 12 September 2020 at 14 Dutch Avenue, Wyndham Vale, Victoria, 3024, from *hyperviscosity-related brain injury secondary to hypernatraemic dehydration*; and
c) the death occurred in the circumstances described above.

COMMENTS

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

1. I consider that a key underlying issue in this case was the family's Medicare ineligibility which resulted in a routine postnatal outpatient review coming with an out-of-pocket expense.

2. I note that babies are not automatically eligible for Medicare just by virtue of being born in Australia: they must have at least one parent who is eligible for Medicare to also be eligible. I consider that this is a considerable failure in healthcare policy which creates unnecessary barriers to accessing essential health care services and has contributed to Siya's death.

3. I am satisfied that the change in policy at Mercy Health to incorporate the first MITH visit into a patient's bundle payment removes this barrier. However, this does not address the underlying issue.

4. The first recommendation I have made below, if implemented, would have the effect of making any baby born in Australia eligible for Medicare regardless of their parents' eligibility.

5. Otherwise, I am satisfied that the changes described by each of the organisations who provided statements to the Court will prevent similar deaths occurring the future. These actions have mostly obviated the need for further coronial recommendations and are commended.

RECOMMENDATIONS

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

(i) That the Minister for Health and Aged Care, The Hon Mark Butler, make an Order pursuant to subsection 6(1) of the *Health Insurance Act 1973* (Cth) to the effect of declaring that babies born in Australia who, but for the Order, would not be an eligible person, shall be treated as an eligible person for the purposes of the same Act.

(ii) That Mercy Health provide a hard copy of the discharge summary to new parents at discharge to include in the *My Health Learning and Development* book (Green Book).

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

Pursuant to section 73(1A) of the Act, I order that a de-identified version of 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:

Chaitali and Yoginkumar Patel
Mercy Health
Hoppers Lane General Practice
Wyndham City Council, Maternal Child Health Service
Department of Health
Department of Premier and Cabinet
Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Signature:

Coroner Katherine Lorenz

Date : 19 August 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.