# Victorian Coronial Inquest into the death of Alex Baptist
September 2007

**Conclusions from:** AUDREY JAMIESON, CORONER

I am unable to provide Nigel and Martha Baptist with an unequivocal depiction of what occurred to Alex on 15 September 2004. I cannot make findings of fact based on unsubstantiated assertions or hypotheses.

Regrettably, the cause of Alex's collapse on 15 September 2004, remains unascertained. Anaphylaxis remains a likely cause but equally so does a sudden unexpected primary cardiac arrhythmia. In the absence of unequivocal evidence of exposure to, and ingestion of an allergen, I cannot exclude a primary fatal cardiac arrhythmia occurring in isolation to exposure to, and ingestion of, an allergen, as a cause of his death. The lack of any cutaneous signs and symptoms including oedema of the tongue and / or vocal cords is influential, but not determinative to my conclusions. I accept that "collapse" may of itself be the only indicator - albeit rare, of anaphylaxis. It may equally be the only indicator of a sudden onset of a fatal arrhythmia. To conclude that death was caused by anaphylaxis would be to rely on proofs that are not logically persuasive, inexact, indefinite and based on indirect inferences.[13]

The evidence does not enable me to provide Nigel and Martha any relief to what can only be described as their agony. Martha took their enthusiastic 4 year old son to kindergarten on the morning of 15 September 2004, and left him to participate in his session. He did not return home again. It is understandable that Nigel and Martha have sought answers to the sequence of events leading to Alex's death.

Having regard to their personal grief, the efforts of Martha and Nigel Baptist to heighten public awareness about anaphylaxis is commendable. This comment should not however be interpreted as condoning their targeted attack on individuals. Systemic change is not achieved through this approach. There is no evidence that anyone has acted with bad faith.

I make no adverse comment in relation to how the staff of Eversham Road Kindergarten handled the emergency situation on 15 September 2004. They acted promptly and appropriately having regard to their positions and to Alex's presentation. None of the staff had ever been

13 See *Briginshaw v Briginshaw* (1938) 60 CLR 336
14 See also Exhibit 12 - Article - R. S. Pumphrey,*Lessons for management of anaphylaxis from a study offatal reactions*, Clinical and Experimental Allergy, 2000, Volume 30, pages 1144-1150.

confronted with such an emergency situation previously. They acted primarily with Alex's welfare in mind and concentrated the trained staff for these purposes while the volunteers attended to the other children. Ms Curnow had the foresight to attempt to use Alex's EpiPen. It is not entirely surprising that she failed to inject Alex but instead, injected herself. We heard anecdotal evidence that trained health professionals have done the same thing during an emergency.

It is not apparent that the administration of the EpiPen would have altered the outcome. We know from Professor Loh's evidence that patients can still die despite receiving adrenaline and other optimal treatment promptly[14]. Implementation of the Management Plan would have required Toni Nichols to recognise that Alex had "collapsed" rather than being desperate to go to the toilet and / or suddenly fallen ill.

With the benefit of hindsight the "best case scenario" may have been the administration of the EpiPen in the playground as it may have provided some assistance as a primary first aid for anaphylaxis, or for some forms of cardiac arrhythmias however, accepting the evidence of the depiction of events, Ms Nichols acted in an appropriate and reasonable manner. She removed Alex from the playground, took him to the bathroom in response to his request to go to the toilet and asked for assistance. The Management Plan was implemented immediately Ms Curnow entered the bathroom. Whether the administration of the EpiPen at that time would have altered the outcome is merely speculative. At best the accidental self administration was a missed opportunity to provide certainty. In the absence of evidence to support certainty, it serves no purpose to further speculate.

**FINDING:**
On the application of any test, including Occam's Razor[15], I am unable ascertain the cause of Alex's collapse and subsequent death.

In accordance with section 35(2) of the *Births, Deaths and Marriages Registration Act* 1996, I direct that there be a correction of the registrable information in the Register of Deaths to reflect that the **cause of death** of **Alexander Baptist** is **unascertained**.

**Further Comments and Recommendations:**
Notwithstanding my Finding as to the cause of death of Alex, it is

15Occam's Razor - The fewer assumptions an explanation of a phenomenon depends on, the better it is.

important to acknowledge that his death has highlighted some of the shortcomings in public awareness of anaphylaxis and that at the time, training for teachers under the auspices of Department of Human Services lacked rigor. Improvements have occurred with Evesham Road's own practices and procedures, and their teachers have undergone additional training in first aid and specific training in the management of anaphylaxis. The Department of Human Services has also injected additional funding into training although it appears that there remains a lack of performance indicators of this training. Nigel and Martha Baptist, with the assistance of Anaphylaxis Australia, have improved public awareness. These are all positive developments arising out of the tragedy of Alex's death.

I also acknowledge that more needs to be done. There are significant numbers of children attending child care centres, kindergartens and schools with allergies and at risk of anaphylaxis These children, their parents and carers and teachers alike deserve to have in place a coordinated approach to minimising the risk of future fatalities.

Mr Vassili submitted that there were a number of recommendations that I should make to address the management of anaphylaxis in the community. I have considered them all.

In relation to protocols at the Victorian Institute of Forensic Medicine for retaining stomach contents in cases likely to be associated with anaphylaxis, I am satisfied that this in fact occurs and that the failure to do so in Alex's case was an isolated oversight.

In relation to a Register of Deaths consistent with anaphylaxis, Anaphylaxis Australia would appear to be the appropriate national body to undertake this specific research. The National Coroners Information System[16] has statistical information about registered causes of death that can be accessed by research agencies.

16The National Coroners Information System (NCIS) is a national internet based data storage and retrieval system for Australian coronial cases. Information about every death reported to an Australian coroner since July 2000 (January
2001 for Queensland) is stored within the system, providing a valuable hazard identification and death prevention tool for coroners and research agencies.

17r26. **Staff to have first aid training**
The proprietor must ensure that at least one staff member on duty whenever children are being cared for or educated by the children's service has first aid training in emergency life support and cardio-pulmonary resuscitation, convulsions, poisoning, respiratory difficulties, management of severe bleeding, injury and basic wound care appropriate for those children.

I adopt in part, proposed recommendations regarding the Department of Human Services.

**I recommend** that DHS in conjunction with the Department of Education and Early Childhood Development establish a working party comprising suitable stakeholders, develop clear guidelines and protocols for all pre-schools and schools on the management of children with allergies including the emergency management of anaphylaxis. A co-ordinated approach to training including training already mandated under the *Children's Services Regulations* 1998[17] would strengthen awareness and expertise of carers and teachers throughout the State and provide them with the support they deserve. The working party should also review the standard of basic first aid and anaphylaxis training with a view to setting minimum and advanced training, a system for measuring competencies standards and a requirement for annual updating of accreditation.

The proposal of banning from kindergartens and children's services substances that induce allergic reaction should be able to be achieved through refinement of the existing philosophy behind the *nut free* and the like policies. Removing the opportunity for inadvertent breaches, for example allowing toddlers of volunteers to bring food into a centre or sharing communal food; will strengthen the effectiveness of the policy without the need for adopting a "stop and search" approach of policing the policy. This refinement or scaling down the opportunity for mistakes must be supported by education of children and the parents, such as Evesham Road is now undertaking.

**I recommend** that the working party review the concept of allergen minimisation in particular in the pre-school setting where more often than not, children are dependant upon others to ensure exposure to an allergen does not occur. This review should address what additional resources are required of centres who adopt a specific *nut free* or other allergen free policy, to ensure that as far as possible, the policy will be understood and adhered to.

I also **recommend** that the working party should also examine whether such a coordinated approach to children's services would be more likely to be achieved under the auspices of one department rather than the current arrangement. For example, in relation to pre-schools where teachers are employed, it is not apparent why they are not overseen by the Department of Education and Early Childhood Development rather than the current arrangement with the Department of Human Services.

**I recommend** that the Department of Human Services - Children's Services provide funding to all of its centres for a centre owned EpiPen which could be used as a "back-up" in the event of accidental discharge of the child's own medication or in other circumstances where an additional dose of adrenaline may be deemed appropriate.

It is apparent that the staff of Evesham Road were not provided with any professional support from the Department of Human services or KCV following Alex's death. It was a significantly traumatic, life affecting incident for all concerned.

**I recommend** that the Department of Human Services devise or review its policies and procedures for the provision of support and debriefing to staff and parents directly involved in critical incidents at their centres.
In relation to submissions made by Mr Vassili for a section 18A apology from the pre-school to Nigel and Martha, I find that the provision does not instill in me the power to request an apology.

AUDREY JAMIESON
CORONER

*Further information on the Coronial Inquest into the death of Alex Baptist can be obtained from the Victorian State Coroners Office. Please note this is an excerpt of the final 'Record of Investigation into Death' of Alexander Baptist, deceased 15th September 2004, aged 4 years*