QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Mr S**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	1 October 2025
FILE NO(s):	2024/918
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	CORONERS: Sepsis; Chicken Pox; Varicella Zoster Virus; Pneumococcal Septic Shock; Multiorgan Failure; Inter-hospital transfer.

Table of Contents

Introduction

1. Mr S was born on 16 August 1997 and died on 19 February 2024, at the Princess Alexandra Hospital (PAH). He was 26 years old.

2. A doctor from the PAH reported Mr S's death to the Coroner because his death was identified as a potential healthcare related death within the definition of a reportable death in the *Coroners Act 2003*. The concerns regarding the discharge from the Redland Hospital on Mr S's presentation to that hospital on 15 February 2024, and the care he was then provided on his re-presentation on 18 February 2024 prior to his transfer to the PAH.

3. Mr S died from 'Multi-Organ Failure' due to 'Pneumococcal Septic Shock'.

4. The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. An investigation is about attempting to find the root cause of the incident that precipitated the death and in appropriate circumstances to analyse systemic failures that contributed to the death and to design remedial responses.

5. In making my findings, they are based on proof of relevant facts on the balance of probabilities I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

Circumstances of the Death

6. On 15 February 2024, Mr S presented to the Redland Hospital Emergency Department (ED) with a two-day history of gradual onset chest pain radiating to his back with associated abdominal pain. He was short of breath on rest and exertion but not short of breath on review. He denied any recent illness or fevers. He reportedly felt warm the day prior.

7. At or around 6.30pm, Mr S was assessed. Other than some mild hypertension his vital signs were normal. His electrocardiograph (ECG) and chest x-ray were also normal. His blood results revealed normal electrolytes with a slightly reduced kidney function with mildly elevated liver function test results.

8. At 10pm, Mr S was reviewed again, the Doctor recorded,

   > *Pain has improved after Mylanta. Current pain 0/10. Feels better in himself. BP rechecked 155/96. Advised that all tests reassuring and troponin negative. Blood shoes derangement in LFTs* (Liver function) *which will need followed up by GP. Should also get followed up for further testing with GP ?ECHO ?endoscopy Pantoprazole script prescribed. GP letter given. Advised to represent if nature of pain changes or is not managed with simple analgesia.*

9. On 16 February 2024 at 8.18pm, Mr S re-presented to the Redland ED with abdominal pain for three days and a blanched rash. He had no other gastrointestinal symptoms. A nurse noted Mr S had been to his GP that morning and had a CT scan. The CT scan was reviewed it showed no obvious cause for the abdominal pain but that he had small hiatus hernia with duodenal thickening. Mr S denied any fevers. His observations again showed mild hypertension.

10. On assessment he had some epigastric tenderness. The clinical impression was '?gastritis' and a plan was made for analgesia, bloods, and a CT abdomen and pelvis if the pain persisted. Mr S's blood tests showed he had a mildly elevated white cell count and mildly reduced platelets. His liver test results had worsened. Mr S remained in the ED short stay unit overnight.

11. On 17 February 2024 at 9.41am, a nurse recorded Mr S's partner had reported Mr S had increased pain. On review, Mr S was rating his pain 10/10 (worst imaginable). He requested poison as he no long wanted to live. He was administered analgesia. The nurse noted Mr S had a rash over his anterior trunk and he advised it had started the previous afternoon. He denied any itching/pain or burning. He was reviewed by a doctor who recorded,

    > *Issues: Abdominal pain. ?unlcear cause. CT abdo + pelvis NAD* (no abnormalities detected)*. Review: diffuse abdomen tenderness since yesterday, new abdominal rash since yesterday, not itchy, not able to sleep last night due to pain, pain worsened this morning, nil vomiting, nil diarrhoea, BLO* (Bowels last open) *2 days ago, not passing any wind, O/E looks uncomfortable lying in bed, afebrile, BP: 165/113, HR: 57, O2:98%, new maculopapular rash on anterior chest. x 4 linear erythematous rashes extending from suprapubic to epigastric region, similar pattern rashes found posteriorly, diffuse abdominal tenderness. DRE performed with nurse as a chaperone – hard stood noted. Investigation: Bedside US NAD – no free fluid seen. Plan 1. Pain relief. 2. Microlax Enema 3. Movicol.*

12. Mr S was referred to the surgical team for review and was seen at 2.30pm. Mr S's wife was very frantic and concerned for Mr S. The doctor noted Mr S looked unwell from the end of the bed. The doctor examined Mr S. The doctor recorded,

    > *Not jaundiced. No scleral jaundice. Dry MM* (mucous membranes)*. Pulse regular strong, normal. Cap refill <2 seconds. Maculopapular rash across chest and abdomen – apparently this is new? post Contrast? Abdomen completely guarded even before examination. No particular areas of increased tenderness. Not peritonitic, however very difficult to examine as patient guards all the time.*

13. Further blood tests revealed further increase in his WCC and worsening of his platelet count, and his liver function tests. The surgeon's impression was that there was no identifiable surgical pathology. The working diagnosis was 'acute hepatitis'. Mr S was referred to the Medical Team and was for further coagulation and liver function tests.

14. At 6.29pm, Mr S was seen by another doctor. He noted a detailed history and the events which had occurred to date. He noted the blanched rash. He recorded,

    > *Discussed with gastroenterology reg on call Dr [redacted] at PAH – covering for hepatology. For admission locally, hepatitis screen, daily INR and LFT, cease paracetamol, NSAIDs and herbal medicine. Partner to bring the herbal medicine to hospital to verify if possible, cause of hepatitis. D/w med reg on call – will review for admission.*
    >
    > *…*
    >
    > *Further update from gastroenterology at PAH. Accepted to PAH (Dr [redacted]. Advised for med admit tonight then transfer during the daytime depending on bed situation.*

15. At 7.22pm, Mr S's wife reported Mr S was experiencing chest pain and that he was unable to breathe. On assessment by a nurse, he said he had left sided chest pain radiating to his abdomen and legs. An ECG was completed, and he was attached to telemetry (cardiac monitoring). Mr S case was escalated to the SMO (ED Consultant). Mr S reported he was only experiencing pain in his lower back as his chest pain had resolved. He was administered 5mg of intravenous (IV) Morphine.

16. At 10.38pm, Mr S was febrile (elevated temperature) for the first time, with a temperature of 38.2. His other observations were unchanged. The Registrar was notified. Mr S was not for any paracetamol due to his liver function and was for cooling measures only.

17. On 18 February 2024 at 12.24am, Mr S temperature had spiked further to 39.1. A nurse recorded, 'MO notified of T, ibuprofen given'.

18. At 1.30am, Mr S was febrile and tachycardia with a temperature of 38.2 and a pulse rate of 123. His oxygen saturations had decreased to 91% on room air. A nurse records,

    > *MO notified and advised to give further 5mg morphine and to give 10mg morphine when due thereafter rather than fentanyl. Commenced on 1L O2 via NP* (nasal prongs) *to bring saturations up to 95%. Pt reported feeling better post second dose of IV morphine. Eating Weetbix ATOR* (at time of report)*.*

19. At 5.29am, Mr S was seen by the Medical Registrar. He noted Mr S had an 'Immediately concerning appearance' which included work of breathing (obvious difficulties with breathing). He was bleeding from innumerable small lesions on his forehead, had ongoing abdominal pain, bibasal creps in his lungs, bleeding gums, ecchymoses on his arms, and a diffuse petechial rash on his chest. Mr S was immediately transferred back to a resuscitation bay for further management. He was commenced on IV fluids and antibiotics. There was liaison with the PAH hepatology team. They recommended managing as per sepsis but no specific management of acute hepatitis. The PAH ICU team were consulted and as Mr S did not require ventilation or vasopressor support ICU input was not needed. The PAH ED team were contacted and advised Mr S could not be transferred to the ED as he would be ramped. Hepatology would no longer accept Mr S due to the change in his clinical circumstances. The PAH Haematology team were also approached. Further tests were taken, and treatment was provided to Mr S in the ED.

20. At 8.21am, Mr S was seen by the ED SMO (the ED Consultant) he had seen the previous evening. Mr S has a fever, high pulse rate and high respiration rate. His chest x-ray showed a new right upper lobe opacity which was atypical for consolidative changes of pneumonia. Further, he had worsening thrombocytopenia (blood clotting issues). He noted Mr S trajectory appeared to be worsening and believed Mr S required urgent transfer to the PAH.

21. The SMO discussed Mr S's case with the Metro South Hospital Internal Hospital Transfer team. They were aware of the need for urgent transfer and were trying to find a bed. It was noted there may need to be escalation to the Director of Medical Services if no beds. Eventually the staff were notified that the Executive Director Medical Services at the PAH had been notified about Mr S by the IHT and that he was for transfer to the ED at PAH.

22. At approximately 10am, Mr S was transferred to the PAH ED, arriving at around 10.29am. His condition worsened and he developed septic shock and multi-organ failure.

23. The treating Intensivist at the PAH has provided a summary of the events following the transfer from the Redland Hospital. He states,

> *Knowledge this morning was of Streptococcus pneumoniae bacteraemia in blood cultures at 7 hours from Redlands under Mr S - on vancomycin, meropenem and lincomycin, alongside hydrocortisone for septic shock. With multi-organ failure including respiratory, liver, kidney, DIC and severe circulatory shock.*
>
> *On my arrival Mr S* (sic) *was sedated with midazolam and fentanyl, ventilated on high FiO2 and with an acceptable Vt on PEEP of 18cmH2O given volume overload from resuscitation of septic shock +- correction of DIC with products. He was on inhaled nitric oxide at 20ppm. Oxygenation was ok given this degree of support. Widespread crackles were present on examination.*
>
> *Noradrenaline was at 65mcg.min, adrenaline 10mcg.min and vasopressin 0.04units.hr to maintain MAP>65. Peripherally cold and shut down and in sinus tachycardia.*
>
> *CVVHDF had been commenced with a moderate to - high dose of dialysate and with fluid removal set at 500ml/h to improve oxygenation - this degree of fluid removal was tolerated for about 45 minutes.*
>
> *There was evidence of line site bleeding and bloodstained frothy sputum alongside evidence of purpura fulminans. Hb was stable.*
>
> *IVIg was not indicated as group A strep was not the inciting aetiology.*
>
> *Over the subsequent hours, his shock progressed with escalating doses of noradrenaline and adrenaline required to maintain MAP only of 50mmHg (both on 100mcg.min in addition to vasopressin at 0.04units.h). An echo was done which showed a small but functioning left ventricle with mild right ventricular dysfunction (per verbal report). Dialysis ultrafiltration rate was reduced to allow some fluid equilibration and the dose was increased to account for progressive metabolic acidosis due to hypoperfusion and severity of illness. There was initially some improvement in oxygenation and PEEP was reduced by 2cmH2O in an attempt to offload the right ventricle, with transient improvement in shock state. Lactate continued to rise, however, acidosis progressed and glucose was required to support blood sugars (suggestive of further liver failure). His repeat bloods also demonstrated progression of organ failure. I discussed this with my specialist colleague Dr [redacted] who agreed that the situation was irretrievable in the context of fulminant pneumococcal septic shock with MOF. ECMO was not indicated due the degree of established multi organ failure.*
>
> *I met with his wife and subsequently family friends alongside our bedside nurse and social worker to explain that while initially we hoped for some improvement and ultimately survival, despite maximal measures, Mr S* (sic) *would likely not survive the next few hours. I explained that we will make sure he is comfortable and will support her and her support network as much as we can. I also explained that we will need to liaise with the coroner's office, who may request some further information or tests.*

Mr S (sic) *subsequently deteriorated rapidly despite these maximal supports and became asystolic. He was unsupportable from a cardiovascular point of view and as a result was not discussed with donatelife. I examined him and gave a time of death of 13:14. I had further discussions with his wife and her family friends. They have expressed concerns regarding the care given at Redlands hospital and have also advocated for a coronial postmortem.*

24. On 14 March 2024, the PAH advised since Mr S death, further information has been included in his integrated medical record (ieMR) by an Infectious Diseases Physician dated 5 March 2024. The entry includes information that Mr S's wife had recently presented to the PAH ED with primary chickenpox. Retrospectively, the results of Varicella zoster virus (VZV) DNA detected and VZV igG not detected had been added to Mr S's clinical record. This confirms Mr S had primary chickenpox as an underlying illness complicated by Streptococcus pneumoniae and sepsis. He was on intravenous antivirals (including acyclovir) in the PAH ICU.

Clinical Review

25. Metro South Hospital and Health Service completed a Clinical Review into the care provided to Mr S at the Redland Hospital and the PAH.

26. In summary the author of the Review states:

> *Atypical presentation of primary chicken pox as the presenting symptoms of severe abdominal pain and the rash, was not consistent with varicella, and is a rare condition in adults. This led to varicella not being recognised when rash initially presented, therefore contributing to the primary issue being identified as viral hepatitis and not varicella.*
>
> *The increased risk of Streptococcus pneumoniae sepsis was not considered as primary varicella was not recognised. The medical staff attributed the first documented fever to the provisional diagnosis of viral hepatitis increasing the likelihood of the delay in the recognition of sepsis and subsequently delay in antibiotics.*

27. Further, the author has advised the Redland Hospital had acknowledged the findings surrounding the atypical presentation of varicella infection and the need for early action and documentation around the suspicion of an associated sepsis. It was agreed the Review findings were to be discussed at the Hospital and ED Morbidity and Mortality Meetings and the Clinical Incident Review Committee.

28. It was noted the Metro South Health Interhospital Transfer procedure indicated time critical patients required the same pathway as non-critical patients. They accept this contributed to the pathway for the undifferentiated patient not being clear, which led to the requirement of multiple phone calls to accept and escalate the patient's need to transfer.

29. The recommendation that came out of the Review was,

> *Senior Medical Officer (SMO) Clinical governance will work with the Chief Operating Officer (COO) and stakeholders from all directorates, to develop a service redesign/clinical quality improvement program to develop a robust agreed process for the escalation and transfer of the undifferentiated unwell patient.*

Statements

30. I obtained statements from the various doctors and nurses who treated Mr S. They were provided to the independent expert ED Consultant, to review alongside Mr S's clinical records from the Redland Hospital and the PAH.

Expert Opinion

31. I retained the assistance of Dr Sean Rothwell, ED Consultant to review this case. I posed a series of questions to him. I set those questions out and his responses below.

Please provide your opinion on the management of Mr S on 15 to 18 February 2024 at the Redland ED, In providing your opinion, please include consideration of the following:

- What as the likely cause of Mr S acute pain and was this adequately assessed and managed?

  Mr S's acute abdominal pain was thoroughly investigated with blood tests, two CT scans on the abdomen (one in the community) and an ultrasound. He was also referred to and assessed by the surgical registrar for an opinion regarding the cause of this abdominal pain and tenderness. He was given multiple doses of analgesia for his pain.

  In my opinion, the cause of his pain is not clear even with the benefit of hindsight. Mr S had inflammation of his liver which would explain his initial epigastric/lower chest pain but he progressed to generalised abdominal pain and tenderness. I cannot provide a plausible explanation and this forms part of his atypical presentation.

  In my opinion, his pain was adequately assessed and managed.

  The chest pain on his earlier presentation was adequately assessed and managed.

- It was noted on re-presenting to the ED on 16 February 2024 that Mr S had a rash, it was observed by other clinicians while he was in the ED – was Mr S rash appropriately assessed and managed in the ED?

  The rash was described as a blanched rash, a maculopapular rash and a linear erythematous rash. In my opinion, these are non-specific descriptions and given that Mr S had normal observations at the time, was undergoing extensive investigations and being monitored in hospital, I don't believe anything further was indicated.

  It is worth noting that the rash was not the typical rash of varicella zoster.

- What was the provisional/working diagnosis of Mr S while he was in the Redland ED? Was that appropriate given Mr S signs and symptoms? Should the provisional/working diagnosis have been changed at any time? If so, to what, and when AND On 17 February 2024, at or around 1922 hours, Mr S complained of chest pain and being unable to breathe, and at 2239 hours Mr S's temperature was noted to be 38.2. Was Mr S appropriately assessed and managed in the context of these new developments.

Between the time of his presentation and the early hours of the 18th February 2024, Mr S's working diagnosis was that of hepatitis of unknown cause. The differentials included toxins and infection. The Hepatology team at the Princess Alexandra Hospital were in agreement with this provisional diagnosis. This was an appropriate diagnosis given the only abnormal investigations at that state were Mr S's elevated liver function tests.

The chest pain reported at 19.22hurs was in conjunction with abdominal and leg pain and settled with analgesia. The ECG was normal and Mr S had been assessed for an episode of chest pain the day prior. In my opinion, it was reasonable to monitor Mr S at that stage.

Mr S developed a fever at 22:39hrs. His other observations were normal. Specifically, he was not tachycardic or hypotensive. A fever was consistent with the differential of an infective cause for his hepatitis and at that stage there was no other sign of sepsis. It was reasonable to treat this conservatively.

- On 18 February 2024, at or around 0020 hours, Mr S's temperature had risen to 39.1 degrees. What if any intervention was required at this time.

  This was only 40 minutes after the initial fever. Once again, his other observations were normal. Specifically, he was not tachycardic or hypotensive. A fever was consistent with the differential of an infective cause for his hepatitis and at that stage there was no other signs of sepsis. It was reasonable to treat this conservatively.

- At 0130 hours, Mr S oxygen saturations had decreased to 92% and he was commenced on oxygen at 1L. What if any intervention was required at this time?

  At 0;130hrs Mr S became tachycardic and hypoxic. This was a more significant change in his condition. The medical officer was notified but did not review the patient at the time. And the Queensland Adult Deterioration Detection Score of 5 should have triggered a medical review and vital signs to be taken every 30 minutes. This didn't occur because the nurse noted the patient's pain had settled, he was requesting food and had fallen asleep. He was even eating Weetbix at the time of the review.

  In my opinion, the new tachycardia and hypoxia warranted a medical review at this time. In particular, the hypoxia did not fit with the working diagnosis of hepatitis so should have been an issue of concern.

- Should Mr S have been commenced on the Emergency Department Non-pregnant Adult Sepsis Pathway at the Redland Hospital while in the ED? If so, when should this have been commenced, and what in this case would that involve?

  I think the question should be more focused on whether antibiotics should have been commenced earlier. Mr S had already received most of the components of the Sepsis Pathway such as senior reviews, lactate measurements, blood cultures, looking for source of infection and IV fluids. Sepsis pathways on their own have not been shown to improve outcomes.

There was opportunity to commence antibiotics sooner if Mr S had been reviewed after the 01:30 hours observations. It is reasonable to estimate they would have been given about 3 hours earlier. His other treatment would have been unchanged.

- When or in what timeframe should Mr S have been transferred to the Princess Alexandra Hospital?

  It became apparent that Mr S was becoming more unwell when Dr [redacted] reviewed him. Dr [redacted] communicated this to ICU, ED, hepatology and haematology at the Princess Alexandra Hospital at approximately 05:30hrs. In my opinion, moves should have been made at this stage to get Mr S transferred, regardless of the accepting team. This is what eventually happened 4 5o 5 hours later.

  I think comments such as 'unaccept the patient' and 'can't be transferred because he would be ramped' are not in the best interests of the patient. In saying that, I accept that this situation is a function of a system under considerable workload and access stress.

- There was significant difficult in the Redland Hospital clinicians attempting to arrange transfer of Mr S to the Princess Alexandra Hospital. Please provide your observations and comments on what occurred. Further, please advise what if anything further the clinicians at the Redland Hospital could have done to escalate the transfer of Mr S to the PAH.

  Drs [redacted] and [redacted] has discussions with various specialities at the PAH. Mr S was clearly now very unwell but without a unifying diagnosis that would fit within a particular specialty. However, it was clear he would need tertiary level care for his illness. As outlined above, I think he should have been moved sooner and the conversations should have been focused on what could be done for Mr S, not the appropriateness of different specialties. It seems that his eventually required the intervention of the Director of Medical Services to enable this to happen.

  I don't think the clinicians and Redland's Hospital could have done anything more to escalate Mr S's transfer at the time. I note the internal review by Metro South HHS has identified the need to develop an agreed process for the escalation and transfer of the undifferentiated unwell patient. I agree that this needs further improvement.

- Was there any action that could have been taken by the Redland Hospital which would have altered the outcome for Mr S?

  Mr S could have been commenced on antibiotics to treat the Streptococcus sepsis sooner if he had been reviewed when it became clear he was deteriorating. However, I don't think this is likely to have changed the outcome. Mr S had an atypical severe illness that had likely been progressing undetected for the last 48hrs. I don't believe commencing antibiotics 3 hours sooner would have altered the course of the illness.

- Please provide any additional information which may assist me in my investigation into Mr S's death.

  Mr S died from Streptococcal sepsis that presented with acute liver inflammation. He showed no other signs of infection, his CRP and lactate were not grossly elevated and his Chest x-ray, CT abdomen and ultrasound were all normal until very late in the illness. He may also have had primary varicella zoster. In my opinion, there are still unanswered questions about the diagnosis and sequence of acute liver failure, Streptococcal infection and varicella infection.

  This is a very rare and unusual case with a tragic outcome. Although his transfer to the Princess Alexandra Hospital may have been more timely, his initial treatment was appropriate and I don't think a transfer a few hours sooner would have changed the outcome.

Response from the Redland Hospital and the PAH to Dr Rothwell's Report

32. Metro South Hospital and Health Service were provided the opportunity to review and respond to Dr Rothwell's report.

33. It is acknowledged that a diagnosis of sepsis could most reasonably have been made at 1.30am on 18 February 2024. The expectation at this point would have been a direct review by the treating medical officer. This would be the standard of care within the department in line with the Queensland Health Adult Sepsis pathway (the sepsis pathway). Metro South Health recognised that the medical review did not occur in this instance and acknowledge the loss of opportunity to commence antibiotics due to the delay in medical review when Mr S clinical deterioration was escalated.

34. I have been advised:

    a) Metro South Health delivers education about the sepsis pathway in a regular cyclical fashion to the cohort of Junior Doctor rotation through the Emergency Department and to the Registrar Education. Further, the sepsis pathway is readily available online with links published on the departmental guideline.

    b) Mr S's case was presented to the Clinical Incident Review Committee.

    c) Mr S's case was presented to the Redland Hospital Departmental Mortality and Morbidity meeting.

35. In relation to Dr Rothwell's comments regarding there being 'still unanswered questions', Metro South advises,

    Mr S had severe streptococcal infection, with several blood cultures growing streptococcus pneumoniae. He also had active Varicella zoster infection, with a positive PCR on blood and a forehead lesion. These were clear and definite diagnoses. The sequence of which came first was less clear.

36. The Hospital agrees that it was not in the best interest of Mr S for the PAH not to accept him for transfer when clinically indicated because of bed capacity constraints, recognising the system is under considerable workload and access stress. As a result of Mr S's case, the Interhospital transfer procedure has been updated. The principle for safe patient transfer is that transfer of critically ill patients will not be delayed due to bed availability at a receiving facility. The Chief Operating Officer of Metro South Health states,

> *Metro South Health notes that there are real and persisting problems with getting sick patients accepted to the PAH when they do not fit neatly into a single speciality. If they are unwell enough to clearly need ICU, then they come to ICU directly. PAH ICU sorts out the transfer directly because they deal with multisystem problems routinely. The IHT system has minimal involvement with the ICU transfer process. Once ICU accepts the patient, they are promptly transferred to the PAH.*
>
> *A limitation of this process is that the PAH ICU have a high threshold for ICU admission, because of a shortage of ICU beds. If this severity of illness I not initially apparent, it can be very difficult for outside clinicians to get such a patient accepted at PAH under a non-ICU clinician. Mr S's case was a clear example of this. The underlying cause is insufficient hospital beds for the clinical demand. Metro South Health is building 30 new ICU beds at PAH, which should relieve some of the bed pressure.*
>
> *Further, Metro South Health will be opening an ICU at Redland Hospital. This would allow patients at Redland Hospital to be assessed by a clinician experienced in managing critically ill patients on site. The new ICU at Redland Hospital would also assist in direct transfer between ICU facilities.*
>
> *Further, Metro South also published patient distribution case review guidelines. This document aims to improve the governance and review of patient care impacted by delayed escalation and IHT transfers. A reference group was stood up to support the implementation of this guideline across the health service.*

37. I sought clarification from Clinical Excellence Queensland as to the statewide protocol in place to ensure timely transfer of critically ill patients. There is a Protocol for management of inter-hospital transfers in place. It was commenced on 1 October 2021 with a review date of 1 October 2024. The key points are that:

    - There is a senior clinical available for each facility 24/7 as a single point of contact to address. access issues related to critically ill patient transfers.
    - The transfers of critically ill patients will not be delayed due to bed availability.
    - A patient with an undifferentiated condition requiring further specific investigations prior to placement in an inpatient bed will not be transported directly ton an inpatient bed.
    - In the event of a disagreement surrounding transfer, consultations must occur between the most senior Medical Officer available and the Bed Manager. If disagreement remains unresolved, the matter is to be escalated to the Director of Medical Services or equivalent at both facilities.

Conclusion

38. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings required by s 45(2) of the *Coroners Act 2003* in relation to Mr S's death.

39. Mr S had an evolving serious illness. His symptoms were not specific, and it was difficult for the treating team to identify what was causing his illness. He was thoroughly investigated. The rash on his body was not identified as varicella as it was an atypical rash. I consider the care up until around 1.30am on 18 February 2024 to have been reasonable. It is acknowledged that more was required after this, and that Mr S should have been reviewed and commenced on intravenous antibiotics at this time. Further, that he should also have been commenced on half hourly observations with arrangements made for an acute transfer to the PAH.

40. This oversight led to around a three hour delay in commencing intravenous antibiotics for Mr S's evolving sepsis and a delay in his transfer to the PAH. Dr Rothwell is of the opinion due to the severity in Mr S's evolving critical illness, the earlier administration of antibiotics is unlikely to have changed the outcome for Mr S.

41. There was an issue in the case in facilitating a timely transfer to the PAH. Mr S had become critically ill by 5.30am. Despite trying, the Medical Registrar could not arrange transfer. The case was eventually escalated, and Mr S was transferred at 10am. In accordance with the Statewide protocol, this matter should have been escalated sooner with an acute transfer to the ED at the PAH in the early hours of 18 February 2024. Dr Rothwell is again of the view, given the severity of Mr S's illness, sadly earlier transfer by five hours is unlikely to have changed the outcome for Mr S.

42. The Health Service comprehensively reviewed the case and provided an appropriate response to Dr Rothwell's report. I am satisfied appropriate measures have been implemented to try and prevent this type of incident from occurring again. On this basis, I am not satisfied that it is in the public interest to hold an Inquest (formal court hearing). There are also no outstanding issues that would justify the resources required for the use of the judicial forensic process. On that basis I have determined that an Inquest is not required.

43. I do though consider this case should be shared widely with clinicians to raise awareness of Mr S's atypical presentation, the need for early intervention in circumstances of potential sepsis, and the issue of the inter hospital transfer issues which arose in the case. I have sought approval from Mr S's wife to publish a de-identified version of the findings on the Coroners Court of Queensland website. A copy of my findings will also be provided to Clinical Excellence Queensland and the Office of the Health Ombudsman.

44. I extend my condolences to Mr S's wife, family, and friends for their loss. This is an unimaginable tragedy for you all. I recognise there are no words which can adequately express the depth of your sorrow, or the profound impact Mr S's loss has had on you all.

Identity of the deceased – Mr S

How he died – 1(a) Multi-organ failure
1(b) Pneumococcal septic shock

Place of death – Princess Alexandra Hospital WOOLLOONGABBA QLD 4102 AUSTRALIA

Date of death– 19/02/2024

1(a) Multi-organ failure
1(b) Pneumococcal septic shock

I close the investigations.

Melinda Zerner
Coroner
CORONERS COURT OF QUEENSLAND - BRISBANE OFFICE

1 October 2025