

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 002319

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	Peter Charles White, Coroner
Deceased:	Nghi Trieu Gla Pham
Date of birth:	1 August 2012
Date of death:	16 May 2017
Cause of death:	Complications of T-cell lymphoma
Place of death:	Parkville

I, PETER CHARLES WHITE, Coroner,
having investigated the death of NGHI TRIEU GLA PHAM
without holding an inquest:
find that the identity of the deceased was NGHI TRIEU GLA PHAM
born on 1 August 2012
and that the death occurred on 16 May 2017
at the Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria 3052
from:

I (a) COMPLICATIONS OF T-CELL LYMPHOMA

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Nghi Trieu Gla Pham [hereinafter 'Nghi'] was a 4 year old boy who lived with his mother, grandmother and brother in Deer Park. His parents are divorced but Nghi had regular contact with his father. Nghi's mother, Thi Oanh Kieu Pham, had limited English language skills, her primary language being Vietnamese. Nghi did not have a significant medical history. He had no allergies nor regular medications and his immunisations were up to date.
2. On 9 May 2017, Nghi presented to Sunshine Hospital¹ with a four-day history of facial swelling, noisy breathing, cough and runny nose. He had completed two days of an oral antibiotic, cephalexin, prescribed by a general practitioner at the onset, which had failed to resolve his symptoms.
3. Nghi was examined in the emergency department [ED] by paediatric registrar, Dr Melissa Barnett. She noted that he had been lethargic with decreased intake of solid food but adequate intake of fluids, and that there had been no change in bowel actions. His voice and vision was unchanged and Nghi was afebrile with vital signs within the normal range. Noisy breathing consistent with nasal obstruction and a soft stridor² was noted, but Nghi's rate and work of breathing was normal and auscultation of his chest was unremarkable. Examination of Nghi's abdomen, which occurred while lying flat, a further indication of unobstructed breathing at that time, was unremarkable. There was facial swelling to his nasal bridge, bilateral temporal region and ears but no facial tenderness. Examination of his ears demonstrated erythematous tympanic membranes³, more so on the left than right, with possible left haemotympanum⁴ which was attributed to a left middle ear infection. Dr Barnett noted bilateral significant

¹ Sunshine Hospital is a part of Western Health.

² A harsh vibrating noise when breathing, caused by obstruction of the trachea or larynx.

³ The membrane which forms the eardrum, between the outer and middle ear.

⁴ The presence of blood in the middle ear.

lymph node enlargement to the submandibular region⁵ and some fullness of the anterior neck, which prompted her to do the Pemberton's test⁶ for 20 seconds, the results of which were negative.

4. Nghi's presentation was discussed with paediatric registrar Dr Melinda Morpeth who also examined him. Although Nghi was discussed with emergency consultant Dr Ilsa Spillane, it is unclear if the discussion occurred before or after a referral to the Ear Nose Throat [ENT] was initiated. It is similarly unclear whether Dr Spillane physically reviewed Nghi.
5. ENT registrar Dr Joo Koh examined Nghi and found there was no stridor nor abnormal eye movements or vision. He noted moderate cervical lymph node enlargement and generalised swelling of his forehead and no evidence of Pott's puffy tumour⁷. A flexible fiberoptic nasolaryngoscopy⁸ examination [FNE] performed at approximately 3.00pm showed near total obstruction of the postnasal space secondary to swollen adenoids, consistent with moderate adenoiditis. Nghi's larynx appeared normal and his nasal cavity did not have significant mucus. The differential diagnosis was sinusitis, upper respiratory tract infection or venous sinus thrombosis.
6. Nghi was admitted by the ENT team under consultant Ms Jessica Prasad for further observation and management. He was administered prednisolone and started on oral antibiotics. Nghi's full blood test [FBE] and C-reactive protein (CRP)⁹ level was normal. Blood film showed normal morphology.
7. Dr Koh reviewed Nghi again at 8.15pm, when he appeared comfortable, with decreased facial swelling and resolution of stridor. Dr Koh's impression was partially treated sinusitis and adenoiditis. After discussing Nghi's case with consultant Mr Simon Ellul, Dr Koh commenced treatment consisting of intravenous antibiotics, oral prednisolone, decongestant nasal spray and saline flush.

⁵ The area situated beneath the jaw or mandible.

⁶ A manoeuvre to assess for thoracic inlet obstruction. The test is positive when the arms are both raised for 30 seconds and marked facial plethora, cyanosis or respiratory distress develops.

⁷ A non-neoplastic complication of acute sinusitis characterised by primarily subgaleal collection, also subperiosteal abscess and osteomyelitis. Usually related to the frontal sinus but sometimes also related with the mastoid. Forehead swelling is seen, which is caused by subgaleal collection and explains the name of this pathology.

⁸ The endoscope, a flexible medical instrument, is used to visualise the nose, nasopharynx (the cavity behind the nose and mouth), and larynx (the voice box).

⁹ The C-reactive protein [CRP] is a protein in the blood that participates in the immune response to pathogens and tissue inflammation. It is a sensitive but non-specific marker of infection or inflammation occurring at some site in the body. It is not specific for any diagnosis, but its elevation can be a 'flag'.

8. During a ward round on 10 May 2017, Nghi was reviewed by the ENT registrar Dr Rotman and resident Dr Barberi who found that he had mild nasal secretions, grade III-IV tonsils,¹⁰ no quinsy¹¹ and was able to move his head from side to side freely. Ms Pham reported that his facial swelling and snoring had improved.
9. On 11 May 2017, Nghi was reviewed by Dsr Koh and Barberi. They noted decreased facial swelling and normal vital observations. Nghi was asleep and they noted “noisy breathing”, with the possibility of obstructive sleep apnoea. When the results of repeat blood tests demonstrated a normal FBE and CRP, Nghi was discharged home with a referral to the ENT outpatients clinic for further assessment of suspected obstructive sleep apnoea. Dr Koh noted (in retrospective notes dated 13 May 2017 that, given Nghi was clinically improving, a decision was made not to perform a CT scan of his sinuses. Nghi does not appear to have been reviewed by an ENT consultant during his admission.
10. After discharge, Nghi’s cough increased and became productive of yellow sputum and developed a barking quality.
11. On the morning of 13 May 2017, Nghi had difficulty breathing and the stridor returned. At 12:28pm, he presented to general practitioner, Dr Phuong Huu Pham, who observed that Nghi appeared unwell, had stridor, noisy breathing and was struggling to breathe. His throat appeared to have pharyngitis and on auscultation of his chest, he had bilateral crackles. Dr Pham referred Nghi urgently to the Sunshine Hospital ED with concerns of croup or epiglottitis.
12. On presentation to triage at 2.28pm, Nghi was noted to have a respiratory rate of 24 (normal range), an elevated heart rate of 132 beats per minute, oxygen saturation of 93%, and normal temperature of 36.9 degrees. He appeared pale, with mild work of breathing, a wheeze and soft stridor. He was triaged as a category two patient and was initially reviewed by the paediatric ED resident.
13. Within one or two minutes of arrival into the paediatric emergency cubicles, Nghi became lethargic, with biphasic stridor and moderate to severe work of breathing. ED registrar Dr Claire Joyner, examined Nghi and noted that his stridor did not appear as the classic stridor of croup, as it was lower in tone. She called Dr Koh at 2.54pm to inform him of Nghi’s re-presentation with stridor. He advised her to treat it as croup and so nebulised adrenaline was

¹⁰ Grade III tonsils are tonsils that extend beyond the pillars but do not reach the midline. Grade IV tonsils are tonsils that extend to and may touch at the midline.

¹¹ An abscess in the tissue around a tonsil usually resulting from bacterial infection and often accompanied by pain and fever

commenced. However Nghi continued to deteriorate so was transferred to the resuscitation area.

14. By this stage, Nghi was in severe respiratory distress and an ED consultant attended to assist. An intravenous cannula was inserted. Shortly thereafter, at 3.11pm, Nghi went into respiratory arrest, then cardiac arrest. Cardio-pulmonary resuscitation was commenced and a Code Blue was called. The anaesthetic team arrived at 3.15pm, whereupon Nghi was intubated and pulseless electrical activity¹² was noted on the defibrillator. Three doses of adrenaline 200mcg were administered as well as two normal saline boluses, dexamethasone, ceftriaxone and flucloxacillin. Spontaneous circulation was restored after approximately five minutes. Blood gas taken at 3.33pm showed severe acidosis in keeping with the outcome of cardiac arrest.
15. Dr Chris Mckenzie contacted the Paediatric Infant Perinatal Emergency Retrieval (PIPER)¹³ team at 3.15pm. The PIPER team, comprising of Dr Andrew Clift and Dr Sai Shankar, arrived at 3.55pm. It was noted that Nghi was difficult to ventilate, requiring high pressures, and his oxygen saturations remained low in the 70s. Some improvement to oxygen saturations was observed when Nghi was placed laterally right side down.
16. Initial chest X-ray showed that the endotracheal tube [ETT] was in the right main bronchus and it was pulled back, with good position on repeat X-ray. The chest X-ray showed a large superior mediastinal¹⁴ mass compressing the trachea and left main bronchus. A bedside echocardiogram showed that cardiac function was good whilst Nghi was in the right lateral position. Due to ongoing difficulties in ventilation, however, the decision was made at 4.15pm to change from mechanical to manual ventilation.
17. At 5.45pm, Nghi was transferred to Royal Children's Hospital [RCH]. During transfer, he again became difficult to adequately ventilate, and subsequently became bradycardic and hypoxic. Chest compressions were commenced with further adrenaline and normal saline administered.
18. Nghi arrived in the Paediatric Intensive Care Unit [PICU], where the cardiothoracic unit was on standby, within eight minutes of cardiac arrest. His chest was surgically opened on arrival to PICU with subsequent return of circulation and ability to ventilate. In total, Nghi had a prolonged arrest time of eight minutes at Sunshine Hospital and 33 minutes during transfer to RCH.

¹² Electrical activity on the ECG with no discernible cardiac output (pulse).

¹³ PIPER is a state-wide service which provides accessible and timely expert advice to health care providers for paediatrics and high risk obstetric care.

¹⁴ The mediastinum is the cavity in the chest between the pleural sacs of the lungs that contains all the tissues and organs of the chest except the lungs and pleurae.

19. Upon opening of Nghi's chest, a large tumour mass was seen in the mediastinum obscuring and pushing down the heart. The tumour was debulked with intermittent complete obstruction of the ETT during handling of the superior mediastinum. Tumour tissue sent to histopathology was consistent with T lymphoblastic lymphoma.
20. Nghi was admitted under the Oncology team whilst he remained in PICU. Chemotherapy was commenced for his lymphoma (dexamethasone, vincristine D1, daunorubicin D2).¹⁵
21. Nghi was reviewed by the Infectious Disease team and continued on broad spectrum intravenous antibiotics and antifungal agents. His chest was left open to allow for ventilation. He required inotropes for blood pressure support and haemofiltration was instituted to support renal function.
22. On 14 May 2017, Nghi developed abnormal movements and was started on an anticonvulsant medication (Keppra) with no further abnormal movements noted. A CT scan of his brain showed features suggestive of hypoxic brain damage. Nghi continued to be critically unwell and required ongoing respiratory support.
23. On 15 May 2017, magnetic resonance imaging [MRI] of Nghi's brain was performed, which showed severe profound global hypoxic ischemic brain injury, with superior and inferior cerebellar herniation and early hydrocephalus¹⁶. He was reviewed by neurologist Dr Andrew Kornberg who noted that Nghi had suffered a devastating neurological injury that would likely result in brainstem herniation in the near future.
24. Overnight, Nghi was haemodynamic unstable and his pupils became fixed and dilated at 3.46am on 16 May 2017. Throughout the day, there were multiple prolonged meetings between PICU, oncology, social work and pastoral care clinicians and Nghi's family with the support of a Vietnamese interpreter. The results of Nghi's MRI, along with clinical examination findings were explained as indicating significant irreversible brain injury. Clinicians advised that intensive care measures would not be able to offer a chance of improvement and would be unable to keep Nghi alive. The medical teams (PICU, oncology, neurology) expressed the view that imminent withdrawal of care was in Nghi's best interests. The diagnosis of lymphoma was discussed and described as "an aggressive malignancy and likely acute onset consistent with his presentation".
25. After formal brainstem testing by two consultants, Nghi was pronounced brain dead on 16 May 2017 at 8.08pm. His heart stopped beating 00.10 on 17 May 2017.

¹⁵ Chemotherapy was ceased (except dexamethasone) on 15 May 2017, two days after his admission to PICU.

¹⁶ A build-up of fluid inside the skull that leads to brain swelling. Hydrocephalus means "water on the brain."

26. Nghi's family were opposed to an autopsy and so none was performed. Instead, forensic pathologist, Dr Gregory Young of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, Nghi's Western Health and RCH medical records, post-mortem computer assisted tomography [PMCT] scans of the whole body and performed an external examination. Among Dr Young's anatomical findings on inspection were evidence of medical intervention and, on PMCT, a large mediastinal mass, 'white out' of the right lung and loss of grey-white matter differentiation in the brain.
27. In the absence of an autopsy, Dr Young advised that it was reasonable to attribute Nghi's death to natural causes, namely, complications of T-cell lymphoma. The pathologist noted that T-lymphoblastic lymphoma is a cancer of white blood cells which commonly involves the mediastinum (thymus) and that it is a lymphoma that may be seen in childhood.
28. Nghi's family raised concerns about why diagnosis of T-cell lymphoma was not made during his initial presentation to Sunshine Hospital.¹⁷ The family had concerns regarding why the diagnosis of T cell lymphoma was not made at initial presentation to Sunshine Hospital.
29. In light of the family's concerns and at my request, the Health and Medical Investigation Team [HMIT]¹⁸ of the Coroners Prevention Unit reviewed Nghi's medical records and recommended that additional statements be obtained from clinicians involved in his management at Sunshine between 9 and 11 May 2017, and concerning any case review conducted at RCH following his death. Although much of the statements subsequently provided by Dr Barnett, the paediatric emergency registrar who initially assessed Nghi at Sunshine Hospital, ENT surgeon and Head of ENT at Western Health, Mr Simon Ellul, and Associate Professor Meredith Allen, Clinical Lead for Quality within the Strategy & Improvement Department of the RCH, has been incorporated into the chronology above, the details that follow are significant.

The Statement of Dr Barnett

30. Dr Barnett reported that she obtained Nghi's history with the assistance of his aunt who acted as an interpreter for Nghi's mother, who had declined a formal interpreter. Dr Barnett emphasised that on examination Nghi appeared well, and was sitting up in bed playing on an

¹⁷ Family concerns were not available in a written statement or email as is customary in this jurisdiction. Rather, family concerns were documented on the Medical Enquiry Form taken 16 May 2017 by Medical Liaison Nurse, Sarah Long.

¹⁸ The HMIT is part of the Coroners Prevention Unit [CPU] established in 2008 to strengthen the prevention role of the Coroner. CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published. HMIT is staffed by practising physicians and nurses who are independent of the health professionals or institutions involved. They assist the Coroner's investigation of deaths occurring in a healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement so that similar deaths may be avoided in the future.

electronic device. He appeared to have slightly cyanosed lips which resolved minutes into the consultation and some swelling to the nasal bridge and anterior to the maxilla. Dr Barnett compared Nghi's appearance to recent photographs provided by his mother, and he did not appear overtly swollen. He had no work of breathing and spoke full sentences with ease. A Pemperton's test was done to assess for superior vena cava¹⁹ obstruction from a mediastinal mass, this was negative. His family was asked if he slept propped up and they said no; he had been sleeping as usual. This indicated that he did not have obstructed breathing when lying flat.

31. Dr Barnett reviewed Nghi with Dr Melinda Morpeth, paediatric registrar, who confirmed a possible soft stridor but he otherwise appeared well. Dr Barnett gave a dose of oral prednisolone (1mg/kg) given the unusual breathing.
32. Dr Barnett discussed the case with the consultant in charge, Dr Spillane, but Dr Barnett is unclear whether Dr Spillane reviewed the patient as well.
33. Dr Barnett referred the patient to ENT Registrar Dr Koh and was present for the ENT assessment including naso-laryngoscopy, which Nghi tolerated very well.
34. Dr Barnett's differential diagnoses included sinusitis and upper airway infection. She commented that she did consider the possibility of a mediastinal mass and did mention her consideration to Dr Morpeth and Dr Koh. Her examination indicates that she did consider the possibility of a mediastinal mass. Given Nghi had no signs of severe illness and no signs of superior vena cava obstruction, Dr Barnett decided there was no indication for a chest X-ray at that stage. She was reassured that he would be observed during the admission and, if his stridor was confirmed, that further investigations could take place at that juncture.

The Statement of Mr Ellul

35. Mr Ellul was contacted by Dr Koh following his review of Nghi on 9 May 2017. Dr Koh reported Nghi's presentation of facial swelling and stridor and that the stridor was not present when Dr Koh examined him, despite Nghi becoming distressed during naso-laryngoscopy examination.
36. Dr Koh indicated that the naso-laryngoscopy examination revealed near total obstruction of the postnasal space by swollen adenoids but a normal-appearing epiglottis and larynx. Dr Koh believed that Nghi may have an upper respiratory infection with adenoid swelling. The plan was to admit him for intravenous antibiotic, oral prednisolone, nasal decongestant spray and

¹⁹ A large vein carrying deoxygenated blood into the heart.

observation. Epstein Barr Virus serology was also requested given the unusual features of the Nghi's presentation.

37. Following his review with the other ENT registrar, Dr Rotman, the following morning, Dr Koh reported to Mr Ellul that Nghi's facial swelling was improving and the stridor had resolved. Mr Ellul recommended that if the child did not continue to improve, he should have an MRI²⁰ of the head to rule out cavernous sinus thrombosis²¹.
38. Mr Ellul did not recall specifically diagnosing Nghi with sinusitis; rather, the presumptive diagnosis was of an upper respiratory infection. He did recall specifically discussing that there was no asymmetry of the facial swelling and therefore no immediate reason to request imaging of the paranasal sinuses. He was reassured that the naso-laryngoscopy examination showed no epiglottitis or laryngeal problem causing the stridor. A chest problem was not considered as the cause of the stridor and facial swelling, hence a chest X-ray was not considered.
39. Over the next 48 hours, Nghi was reviewed daily by the ENT registrars. His facial swelling improved, his stridor resolved and he was able to lie flat with no oxygen desaturations. Nghi's blood tests on day of discharge were normal.
40. Mr Ellul stated that, to his knowledge, Nghi was not reviewed by an ENT consultant during his admission. He indicated that there is no formal guideline or policy regarding consultant review of inpatients. Instead, consultant review occurs at the request of ENT registrars or at the discretion of the ENT consultant, depending on the clinical problem.
41. Mr Ellul observed that Nghi presented with a very uncommon clinical condition (mediastinal lymphoma causing thoracic inlet obstruction)²². He considered the presentation of facial swelling to be unusual and did not consider thoracic inlet obstruction. He further noted that Nghi was only discharged when he had clinically improved and blood tests were satisfactory. On the day of discharge, Nghi's mother indicated that she felt her son had improved and she had no concern about taking him home.
42. Nghi's case was discussed within the ENT unit, amongst the other ENT consultants, at the half yearly audit meeting. The issues and recommendations identified by it were not provided

²⁰ Magnetic resonance imaging (MRI) is a scan used for a medical imaging procedure. A MRI uses a magnetic field and radio waves to take pictures of the body's interior. A MRI is used to investigate or diagnose conditions such as tumours, joint or spinal injuries or diseases, soft tissue injuries or diseases of internal organs such as the brain or heart.

²¹ Formation of a blood clot within the cavernous sinus, a cavity at the base of the brain which drains deoxygenated blood from the brain back to the heart. The cause is usually from a spreading infection in the nose, sinuses, ears, or teeth.

²² A group of disorders that occur when blood vessels or nerves in the space between your collarbone and your first rib (thoracic outlet) are compressed.

in Mr Ellul's statement. However, Ms Ellul commented that 'a lack of daily review and discussion with an ENT consultant is unsatisfactory but impractical given the limited number of consultant ENT staff and their commitments to other public hospitals and private practice'.²³ The ENT surgeon suggested that all paediatric ENT admissions be jointly managed by ENT and paediatric units to facilitate daily consultant review. Communication with Western Health legal counsel indicates that this practice change is under consideration.

43. A formal case review was also performed by paediatric emergency consultant Dr David Krieser, anaesthetist Dr Adriano Cocciante, nurse unit manager of paediatric ward Dianne Patterson, quality assurance officer Jo Miller and Mr Ellul on 24 May 2017 at Sunshine Hospital. Issues that were thought to have contributed were that the mother had limited English and may not have been able to clearly relay the severity of the child's symptoms and signs. In addition, Nghi's response to oral prednisolone likely masked the underlying cause of facial swelling and hence MRI was not pursued. Though an MRI may have led to recognition of distended head and neck veins and suspicion of thoracic inlet obstruction, it would have required a general anaesthetic. Dr Cocciante indicated that undertaking a general anaesthetic would have likely precipitated a respiratory arrest given the size of the mediastinal mass which at the time was unrecognised.

Statement of PICU Consultant, Associate Professor Meredith Allen

44. A/Prof Allen reported that Nghi's case was reviewed at the RCH PICU Morbidity and Mortality meeting. The cardiorespiratory arrest that occurred during PIPER transfer was classified as 'disease related' and 'not preventable'.²⁴ Clinical care, from the point that PIPER became involved, was reviewed and the outcome classified as 'death was a likely outcome and all appropriate management was undertaken'.²⁵ No issues or recommendations for improvement were made.
45. The PICU consultant and PICU social worker met with Nghi's family, including his father, the day after the death. The family were provided information about how to contact PICU or oncology should they have any further questions. A/Prof Allen was not aware if further contact had been made.
46. At my request, the HMIT reviewed the statements of Dr Barnett, Mr Ellul and A/Prof Allen and Nghi's medical records and provided the following advice about the adequacy of his

²³ Statement of Simon Ellul dated 18 February 2018.

²⁴ Statement of A/Prof Allen dated 26 September 2017.

²⁵ Ibid.

management at Sunshine Hospital and RCH, and the likelihood that earlier diagnosis of Nghi's lymphoma would have prevented his death.

47. The HMIT advised:

- a. Nghi presented with the common symptoms of upper respiratory tract infection including runny nose and cough and with the unusual symptoms of facial swelling and stridor. The presentation of a mediastinal lymphoma causing thoracic inlet obstruction is rare.
- b. Dr Barnett considered other differential diagnoses including superior vena caval obstruction in the ED assessment. The case was reviewed by another emergency registrar and discussed with the emergency consultant in charge and the ENT registrar. Given the stridor had resolved, there was no increased work of breathing, normal oxygen saturations and a negative Pemberton's test, it was appropriate to not do a chest X-ray on the day of presentation. Admission for observation and treatment under the ENT unit ensuring further review was appropriate.
- c. The cause of Nghi's stridor was appropriately investigated with fiberoptic nasolaryngoscopy examination. This examination confirmed swollen adenoids and moderate adenoiditis, which explained his noisy breathing. The epiglottis and larynx were normal, which excluded upper airway causes of stridor. He was treated for adenoiditis, an upper respiratory tract infection, with antibiotics, oral prednisolone and nasal decongestant spray.
- d. During the admission, Nghi responded well to treatments. He had improvement in facial swelling. During the admission he had no increased work of breathing and normal oxygen saturations throughout. He was documented to have occasional soft stridor at rest on 9 May 2017, but not throughout the rest of the admission. He was documented to have nasal congestion throughout, consistent with his enlarged adenoids.
- e. Given Nghi's clinical improvement and, in particular the resolution of stridor, there was no further indication to perform a chest X-ray during the course of his admission. In addition, given this clinical improvement, there was no immediate reason to request further imaging. A head MRI to exclude cavernous sinus thrombosis was considered but not requested, given Nghi's clinical improvement. In retrospect it is likely that, given Nghi's undiagnosed condition, the general anaesthetic required for MRI would have precipitated a respiratory arrest given the

size of the mediastinal mass, as indicated by Dr Cocciante, an anaesthetist at Western Health.

- f. The underlying cause of Nghi's facial swelling was his lymphoma causing compression of venous drainage. The daily course of oral prednisolone started during this admission is likely to have masked the symptoms of mass effect caused by Nghi's lymphoma. His symptoms likely recurred following cessation of prednisolone on 11 May 2017. In view of the working diagnosis, the use of a short dose of steroids was standard and appropriate treatment.
 - g. The management of cardiopulmonary resuscitation on 13 May 2017 at Sunshine Hospital ED and on transfer with PIPER were appropriate. Despite appropriate resuscitation, Nghi suffered a profound irreversible brain injury due to prolonged cardiorespiratory arrest.
48. The HMIT concluded that Nghi's medical management at Sunshine and the Royal Children's Hospitals was, in general, considered and appropriate. Reasonable care was provided during his initial Sunshine Hospital admission. Nghi was clinically stable throughout, had improved by the time of discharge and his initial symptoms, particularly the stridor and facial swelling, improved with treatment. Given Nghi's progress, the lymphoma could not be expected to have been identified during this admission.
49. The HMIT considered it unclear and difficult to predict Nghi's response to treatment had his lymphoma been diagnosed earlier. Given the large size of the tumour, there was already significant morbidity and mortality associated.
50. The HMIT identified the use of interpreters and the creation of clear guidance for registrars about escalating patient care for consultant review or discussion as practice improvements to the care provided to Nghi during his Sunshine Hospital admission. It was noted, however, that neither of these factors would have guaranteed the earlier diagnosis of lymphoma.
51. I find that Nghi Trieu Gla Pham, late of Tasman Avenue in Deer Park, died on 16 May 2017 at the Royal Children's Hospital of natural causes, namely, complications of T-cell lymphoma. The available evidence does not support a finding that any want of clinical management or care on the part of Nghi's Sunshine Hospital or RCH clinicians caused or contributed to his death.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act* 2008, I make the following comments connected to the death:

1. Nghi's family were of Vietnamese background and his mother did not speak fluent English. His mother declined an interpreter in the ED and a family member, an aunt, acted as an interpreter. The aunt's level of English proficiency was not documented and apart from her involvement at the outset, there was no other reference in Nghi's medical record to use or the offer of an interpreter, accredited or otherwise.
2. Victoria has one of the most culturally diverse populations in Australia, with more than a quarter of the population born overseas, three-quarters of whom come from non-English speaking countries. Effective communication, particularly in the health care setting, has obvious benefits for patients and the care they receive.
3. In January 2017, the Victorian Department of Health and Human Services issued a Language Services²⁶ Policy in January 2017 [the Policy]. The Policy emphasises the importance of language services to ensuring access to and participation in decision-making processes that have consequences for an individual's life.
4. The Policy also highlights that individuals who are not trained as interpreters generally have little or no understanding of specialist concepts or of the importance of accuracy and completeness of the messages conveyed. In consequence, new information is often added or critical information omitted, which leads to significant changes in the nature of the original messages.
5. Accordingly, the Policy advocates that organisations offer the use of an accredited interpreter to all clients with limited or no English language skills.

RECOMMENDATIONS

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

1. That Western Health ensures that the use of an interpreter is offered at all critical points of communications; such as the initial admission, at critical decision making points and in order to provide discharge education.

²⁶ The definition of language services used in the Policy includes Auslan, the signed language of the Australian Deaf community.

2. That Western Health develops a best practise guideline or clear criteria to guide registrars as to which patients may require a consultant review or, at a minimum, discussion with a consultant.


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

Ms Pham

Nicola Caras, Legal Services, Western Health

Emma Carnovale, General Counsel, Royal Children's Hospital

Signature:



PETER CHARLES WHITE
CORONER

Date:

5 June, 2018.

