IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2007 1720

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of:	ROSALIE ANNE KING
Delivered On:	20 June 2014
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	22 and 24 November 2010
Findings of:	CORONER JACQUI HAWKINS
Representation:	Mr T Wraight appeared on behalf of Royal Melbourne Hospital.
Counsel Assisting the Coroner	Senior Constable G McFarlane

I, JACQUI HAWKINS, Coroner having reviewed the investigation into the death of ROSALIE ANNE KING

AND the inquest[1] held by Coroner Hendtlass on 22 and 24 November 2010 in relation to this death

at MELBOURNE

find that the identity of the deceased was ROSALIE ANNE KING

born on 14 December 1977

and the death occurred on 5 May 2007

at the Austin Hospital, 145 Studley Road, Heidelberg Victoria 3084

from:

1 (a) BRONCHOPNEUMONIA IN A WOMAN WITH BRAIN INJURY

in the following circumstances:

SUMMARY OF CIRCUMSTANCES

1. Rosalie King[2] was a 29 year old Aboriginal woman who died at the Austin Hospital on 5 May 2007. She had been in a relationship with Mr John Herrington since 2002 with whom she was living throughout those years. Rosalie also had children who lived with members of her extended family. Prior to her death, Rosalie was a resident of Ivanhoe Manor Rehabilitation Centre (Ivanhoe Manor) where she was receiving palliative care.

2. On 20 October 2006, Rosalie underwent the first of a number of surgical procedures at the Royal Melbourne Hospital which were required because she had been struck by a motor vehicle on 19 October 2006.

3. On 31 October 2006, Rosalie experienced respiratory arrest and suffered a hypoxic brain injury as a result. Rosalie died approximately seven months later when ongoing treatment at the Austin Hospital was withdrawn.

4. The exact circumstances of the collision on 19 October 2006 are uncertain. What is known is that Rosalie was hit by a motor vehicle on Murray Road, Preston. Prior to the collision, Rosalie had been drinking alcohol with friends and it is believed that she was attempting to hail a taxi.

5. At approximately 11.00pm, a witness in a car driving along Murray Road observed Rosalie lying horizontally across it; it is unclear why or how she came to be there. This witness was able to swerve and avoid Rosalie but the driver of the motor vehicle following her could not avoid a collision and ran over her lower body.

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1 This finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

2 For consistency, I have avoided formality and referred to Rosalie King as Rosalie throughout the Finding.

6. Emergency services were called and Rosalie was conveyed to the ROYAL MELBOURNE HOSPITAL where she arrived at approximately 12.05am on 20 October 2006. On arrival, Rosalie was talking and oriented. Her Blood Alcohol Concentration (BAC) was recorded as .149 per 100mL[3]. Her injuries comprised multiple rib fractures, displaced pelvic fracture and retroperitoneal and pelvic haematoma, disrupted left renal artery, deep lacerations to the left thigh and a fractured left femur.

7. At approximately 3.00am, Rosalie had surgery to reattach her left renal artery and to repair her pelvic fracture. Rosalie was then admitted to the Intensive Care Unit (ICU) for ten days. Whilst there, Rosalie underwent further surgeries and procedures including the application of an external fixation for her pelvic injury, a skin graft on her thigh wound and the pinning of her fractured left distal femur.

8. On 30 October 2006 at 1.10pm, Rosalie was transferred to the Trauma Ward. Rosalie was noted to be alert and orientated with stable vital signs however appeared anxious. On 31 October 2006 at 6.20am, Rosalie reported to medical staff that she was having trouble breathing. Almost immediately, Rosalie suffered a respiratory arrest. A Medical Emergency Team (MET) call was made and at 6.22am a Code Blue[4] was called. At 6.27am, Cardiopulmonary Resuscitation (CPR) was commenced, adrenaline was administered, and at that same time, Rosalie's cardiac output recommenced. However, as a result of the respiratory arrest, Rosalie suffered a hypoxic brain injury.[5]

9. Consequently Rosalie was unable to eat or swallow, could not make any verbal or non-verbal communication, made non-specific spastic, jerking movements of her upper and lower limbs, and was doubly incontinent. Nasogastric feeding was instituted and a tracheotomy was performed to assist with breathing.

10. Rosalie stayed in the ICU for 14 days following her respiratory arrest at which time a decision was made to discharge her to the ward. This decision was made on the basis that there was a diagnosis of moderately severe encephalopathy consistent with diffuse cortical injury, there was poor neurological recovery in ICU and an absence of the requirement for intensive care reports. In light of Rosalie's poor prognosis and after discussion with her family it was decided that Rosalie should not receive CPR if she went into cardiac arrest.

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3 Rosalie's BAC is reported differently in the hospital notes. In the clinical notes at the time of her admission, it is reported that her BAC is .149 per 100mL. In the Anaesthetic Report made at the time of surgery it is reported at being .3 per 100mL however, given Rosalie's presentation at hospital, it is believed it was more likely to be .149 per 100mL. See Transcript of evidence, p14-15.

4 A MET call is made when a patient is deteriorating and a Code Blue is called when a patient has arrested.

5 Hypoxic brain injury is caused by a decrease in the supply of oxygen going to the brain.

11. On 21 November 2006, Rosalie was transferred to Ivanhoe Manor. During her time there, it was noted by staff that Rosalie did not respond to verbal commands or track people with her eyes.[6] Her response to pain was non-specific and included mouth opening and increased respiratory rate. There was difficulty in achieving adequate nutrition with nasogastric feeding due to recurring vomiting which also increased her risk of aspiration.

12. Also during this time, Rosalie had a number of admissions to St Vincent's Hospital and the Austin Hospital with various medical conditions including *inter alia*:

- Between 3 December 2006 and 30 January 2007 – a chest infection that was treated with antibiotics where she developed a metticillin-resistent staphylococcus areus septicaemia (golden staph); difficulty feeding which was assisted by a Percutaneous Endoscopic Gastrostomy (PEG) tube and a small non-functioning left kidney.
- Between 26 and 27 February 2007 – Sepsis and anuric acute renal failure involving obstructed right kidney and non-functional left kidney for which a nephrostomy tube was inserted; difficulty with PEG feeding including gastroparesis.
- On March 15 2007 – Supra Ventricular Tachycardia and a heart rate of 200 beats per minute; febrile, tachypnoea and extreme hypoxia.

13. On 15 March 2007, a meeting was held with Mr Herrington and hospital staff. Rosalie's condition was explained including her brain injury and the unlikely chance of neurological recovery. In addition, the high probability of ongoing infections was also discussed. Mr Herrington did not agree with a Not for Resuscitation (NFR) Order and therefore a full and aggressive treatment plan for Rosalie's medical conditions was put in place.

14. During March and April 2007, Rosalie's prognosis remained poor and she continued to have ongoing complications with infection, artificial feeding, aspiration and pneumonia.[7]

15. Over this period, Rosalie was assessed by numerous medical practitioners involved in her care and it was consistently agreed between them that a palliative care treatment plan should be devised and instituted. Medical practitioners in charge of Rosalie's treatment continued to recommend a NFR order. However, Mr Herrington believed that Rosalie would recover if treatment was reinstated because she was showing signs of responding to him by blinking and moving her head.[8] Therefore and due in part to his cultural beliefs Mr Herrington did not agree.

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6 I note that Mr Herrington believed that Rosalie did respond to him with eye and head movements.

7 The care and management of Rosalie over this time is well documented in *In the Matter of an Application by John William Herrington for a declaration concerning Rosalie Anne King and Austin Health* [2007] VSC 151.

8 Ibid, 17.

16. The evidence indicates that the approach taken by both Mr Herrington and Rosalie's parents to her treatment, and their understanding of what was in her best interests, were grounded in their cultural beliefs about illness and disability. Specifically, they strongly believed that an individual who was unwell should be unequivocally cared for and not left to die.[9]

17. Given that there were irreconcilable differences between Mr Herrington and medical staff about whether further treatment was in Rosalie's best interest, a guardianship application was initiated by the Austin Hospital. However, because on 24 April 2007 Mr Herrington made an application to the Supreme Court for an order to reinstitute active treatment, the application was subsequently withdrawn.

18. After considering all of the evidence put before the Court, Justice Williams declined to make the order on the basis that treatment would be futile, and it would possibly hasten Rosalie's death and cause her further pain and indignity.[10]

19. On 25 April 2007, Dr Premaratne discussed the Supreme Court ruling with Mr Herrington. It is documented that Mr Herrington appeared to accept the ruling. Over the next 12 days, the Austin Hospital indicates that Mr Herrington was provided regular updates and reviews on Rosalie's condition and pain medication.

20. Throughout this period, Rosalie remained generally comfortable and showed no signs of significant distress. On 5 May 2007 at 2.50pm, Rosalie passed away.

JURISDICTION

21. At the time of Rosalie's death, the *Coroners Act 1985* (Vic) (the Old Act) applied. From 1 November 2009, the Coroners Act 2008 (Coroners Act) has applied to the finalisation of investigations into deaths that occurred prior to its introduction.

22. The Coroners Court of Victoria is an inquisitorial jurisdiction.[11] Section 67 of the Coroners Act provides that a coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

23. The role of a coroner in this State includes the independent investigation of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

24. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority

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9 Ibid, 18.
10 Ibid, 24.
11 Section 89(4) of the Coroners Act.

or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[12]

ASSIGNMENT OF INQUEST FINDINGS

25. Coroner Hendtlass retired on 31 December 2013 without completing the inquest findings in this investigation. The State Coroner of Victoria, His Honour Judge Ian Gray, assigned the completion of this Finding into Death with Inquest (Finding) to me pursuant to section 96 of the Coroners Act.

26. In writing this Finding, I have conducted a thorough forensic examination of the evidence including reading all the witness statements contained within the inquest brief, supplementary statements, exhibits and legal submissions. I have read the transcript of the directions hearing and the inquest.

CORONIAL INVESTIGATION AND INQUEST

27. Coroner Hendtlass commenced an investigation and held an inquest into the death of Rosalie on 22 and 24 November 2010.

28. The following witnesses were called to give evidence at the Inquest:

- Associate Professor Rodney Judson, Director of Trauma Services, Royal Melbourne Hospital;
- Dr Noel Atkinson, Vascular Surgeon, Royal Melbourne Hospital;
- Dr David Williams, Intensivist in ICU, Royal Melbourne Hospital; and
- Professor John Cade, Principal Specialist in ICU, Royal Melbourne Hospital

CAUSE OF DEATH

29. Dr Katherine White, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted a post mortem examination on 10 May 2007 and ascribed the cause of Rosalie's death to:

1(a) BRONCHOPNEUMONIA IN A WOMAN WITH BRAIN INJURY[13]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

30. The focus of Coroner Hendtlass' investigation was not on the circumstances of the collision which occurred on 19 October 2006 but rather, Rosalie's medical management at the Royal Melbourne Hospital from 20 October to 14 November 2006. In particular, the focus of the

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12 Sections 72(1) and (2) of the Coroners Act.

13 Dr White noted that this cause of death is "often a terminal event in debilitated patients" Autopsy Report, p11

inquest was the cause of the respiratory arrest and hypoxic brain injury which ultimately led to Rosalie's death.

31. Although Coroner Hendtlass had preliminarily identified the management of Rosalie's renal artery surgery and the communication of radiology results as issues, these were ultimately not considered pertinent to the circumstances of her death and therefore have not been considered as part of this Finding. Rather, I have considered the timing, cause and medical management prior to the hypoxic brain injury.

32. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary touching upon the relevant circumstances investigated as part of the inquest.

Timing of the hypoxic brain injury

33. Professor Cade was of the opinion that the hypoxic brain injury occurred after Rosalie's respiratory arrest. His reasoning was that in ICU, Rosalie was strictly monitored and it would have been impossible for neurological decline not to have been noticed.[14] He does not believe it was a slow onset of hypoxia but due to the relevant event itself. He stated that in the absence of cardiac output even for relatively brief periods there can be significant cerebral damage even with good resuscitation.[15]

34. Dr Williams was in firm agreement and expressed surprise that Rosalie suffered as much hypoxic brain injury as she did because he believed she was resuscitated promptly.[16] He similarly noted in support of this contention that prior to the event, Rosalie did not show a change in neurological function, and there had been no episodes of hypoxia or cardio-respiratory impairment.

35. I therefore find that Rosalie's hypoxic brain injury occurred as a result of the respiratory arrest on 31 October 2006.

The cause of Rosalie's respiratory arrest and hypoxic brain injury

36. A number of differential diagnoses were proffered as the cause of the respiratory arrest including: a pulmonary embolus; fat embolus; acute pulmonary oedema; pneumonia; pericardial effusion/tamponade; or acute intracranial event such as a subdural-, extradural-, or cerebral haemorrhage/infarction.[17]

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14 Transcript of evidence, p58
15 Transcript of evidence, p69-70
16 Transcript of evidence, pp38-39
17 Exhibit 3 – Statement of Dr David Williams, dated 2 March 2009, p2

37. Three of these differential diagnoses were further explored in evidence as part of the inquest. The medical professionals who were called to give evidence gave conflicting and equivocal opinions which are discussed herein.

Thromboembolism

38. The possibility that Rosalie suffered a thromboembolism[18] of some description was considered to be high. However, the medical witnesses who believed this was the case were not in accord about the nature and origin of the thromboembolism.

39. Dr Williams believed that Rosalie likely suffered a pulmonary thromboembolism.[19] His opinion was formed on the bases of the nature of the injuries she suffered, the temporal sequence of the events and her rapid decline. He particularly believed that Rosalie was at significant risk of thromboembolism due to her injuries.

40. However, Dr Williams conceded that his opinion was not supported by the post-event computed tomography (CT) scan which did not show any evidence of an embolism. By way of explanation, he stated that an embolism can break up due to the mechanical effect of external cardiac massage,[20] so it is possible that post-arrest, the embolism dissipated quickly and therefore could not be detected on the CT scan.[21] He did note, however, that from his past experience, it would be expected that there would be some signs of a clot on a CT scan and as such he was not entirely comfortable with this explanation.[22]

41. In any case, he indicated that the best way to avoid a pulmonary thromboembolism is to use anticoagulant medication quite vigorously which was not advisable in this instance because of the risk of a substantive haemorrhage. He noted that Rosalie had suffered a substantial retroperitoneal haemorrhage[23] and the use of anticoagulants would have exacerbated that problem.[24]

42. Associate Professor Judson was of the opinion that it is only an outside possibility that Rosalie suffered a pulmonary thromboembolism. He stated that Rosalie's pelvic injury was a very serious disruption of the pelvis and agreed that when larger bones break there is a

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18 A thrombus is a blood clot that forms inside a vessel in the body and stays there. If thrombi (the plural of thrombus) break loose and move to another part of the body, they are then called emboli (the plural of embolus). The related medical condition where a thrombus has broken free and travelled to lodge in another part of the body is called a thromboembolism.

19 Pulmonary embolism is a blockage of the main artery of the lung or one of its branches by a substance that has travelled from elsewhere in the body through the bloodstream (embolism).

20 Transcript of evidence, p42

21 Transcript of evidence, p34

22 Transcript of evidence, p42

23 Retroperitoneal hemorrhage is an accumulation of blood found in the retroperitoneal space in the abdomen.

24 Transcript of evidence, p39

possibility it could lead to an embolism due to bleeding and the release of fatty material from within the bones into the blood stream.[25]

43. However, he opined that for a pulmonary thromboebolism to have caused her to collapse into respiratory arrest so quickly, it would have had to have been a sizeable clot. A clot of such a size would block a significant part of the circulation to the lungs and consequently would be seen on an x-ray after the event. He confirmed that there was no evidence in the x-rays of any blockages within the lungs.[26]

44. Associate Professor Judson agreed with Dr Williams contention that anticoagulants are usually administered to prevent such occurrences and that this would have been inappropriate for Rosalie.[27] He further noted that additional surgeries were scheduled for Rosalie's other injuries and there would have been a significant risk of further bleeding if anticoagulants were administered.[28]

45. Associate Professor Cade could not be drawn into giving an opinion as to one cause of Rosalie's respiratory arrest. Rather, he believed that it could have been a combination of diagnoses, that each in their own right may have been unable to cause Rosalie's respiratory arrest, but which in combination led to the respiratory arrest, and subsequent hypoxic brain injury.

46. However, his opinion leaned towards there having been a pulmonary event due to the rapid onset of her respiratory symptoms.[29] He agreed that medical staff were shocked to find that the post event scans did not confirm a pulmonary embolus. He concurred with Dr Williams that it is possible for a pulmonary embolus to break up due to prolonged cardiac massage[30] and although a pulmonary embolism cannot be confirmed, it cannot be excluded and it remains high on the list of possibilities.[31]

47. Mr Noel Atkinson concurred with Associate Professor Judson that a clot of such size would have been visible in x-rays post-event.[32]

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25 Transcript of evidence, p7
26 Transcript of evidence, p14
27 Transcript of evidence, p7
28 Transcript of evidence, p19
29 Transcript of evidence, p61
30 Transcript of evidence, p64
31 Transcript of evidence, p65
32 Transcript of evidence, p31

The origin of any thromboembolus

48. Dr William's opinion is that the pulmonary thromboembolism likely occurred as a result of a clot which formed in her deep pelvic veins due to her pelvic fracture and travelled through her heart to her lungs.[33]

49. On the other hand, Professor Cade was of the opinion that the embolism did not necessarily originate from the pelvic veins. The fact that Rosalie had a pelvic injury did not, according to Professor Cade, mean that the clot has formed there. Rather, it would only increase the likelihood that it did.[34] He noted that the most common site of a deep vein thombosis (DVT)[35] is the leg and that even with the use of calf compression the risk of a clot forming there is only reduced by maybe one third.[36]

50. Mr Noel Atkinson considered the possibility that Rosalie's respiratory arrest and subsequent hypoxic brain injury was the result of the operation on her kidney, or from left kidney failure.[37] However, he noted that the only possibility that the operation could have created a blood clot, which would have subsequently become a pulmonary embolism, would be if it was a sizeable clot which formed in the vein draining the kidney. He did not believe that this was the case.

Fat Embolism

51. Associate Professor Judson stated that a fat embolism[38] was an unlikely cause of the respiratory arrest. He noted that fat embolism particles can be much smaller and may not be visible on x-rays.

52. From a detection perspective, a fat embolism can be difficult. It is usually suspected when there are problems with providing the patient with sufficient oxygen post-surgery. If a patient is being administered oxygen and there is difficulty in getting adequate oxygenation of the blood, but all else looks fine on the x-rays, an assumption is usually made that it is likely to be a fat embolism. However, Associate Professor Judson's evidence was that a fat embolism would usually occur within one or two days after surgery.[39] As such, he believed that in Rosalie's case, the respiratory arrest manifested itself too late for it to have been likely that a fat embolism occurred as a result of surgery.

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33 Transcript of evidence, p52
34 Transcript of evidence, p84
35 Deep vein thrombosis (DVT) is the formation of a blood clot (thrombus) in a deep vein, predominantly in the legs.
36 Transcript of evidence, p83-84
37 Transcript of evidence, p29
38 A fat embolism is a type of embolism that is often caused by physical trauma such as fracture of long bones, soft tissue trauma, and burns.
39 Transcript of evidence, p21-22

53. Professor Cade agreed and further noted that Rosalie did not exhibit typical symptoms such as a rash or thrombocytopenia.[40]

54. Precautions such as blood thinning medications are used when patients are stable to prevent clots developing however there is no real prevention for a fat embolism as blood thinning agents have no effect on them.[41]

Pneumonia and Aspiration

55. Associate Professor Judson was of the opinion that it is possible Rosalie suffered a combination of pneumonia and aspiration of fluid into her lungs. She consequently could have developed lowered oxygen intake which caused her to become unconscious and cease breathing. In turn, he contended that the subsequent lack of oxygen to the brain could have caused the hypoxic brain injury.[42]

56. Doctors give directions with respect to whether a patient is to be allowed food which they swallow themselves. They rely on the assessment of a speech pathologist who reviews the patient's ability to swallow without aspirate into their lungs. Rosalie was assessed as safe to commence swallowing. Rosalie was kept under close observation in the ICU and notes were made by medical staff.[43]

57. Conversely, Professor Cade discounts the theory of aspiration of liquid nutrients into the lungs. He does so on the basis that the liquid nutrients would have been apparent in the throat and lungs when she was intubated as part of the cardiac arrest.[44]

Conclusion as to cause of the respiratory arrest

58. Given the differing opinions of the medical witnesses and their own internal uncertainties, I am unable to make a definitive conclusion as to the medical cause of Rosalie's respiratory arrest and consequent hypoxic brain injury.

Appropriateness of the medical management

59. I note that Mr Herrington raised concerns about Rosalie's medical management in his statement. A number of these concerns relate to the decision to cease life support. This was not a focus of the inquest and these issues were the subject of the Supreme Court proceedings. I am unable and unwilling to second guess the appropriateness of this decision and have therefore not considered these concerns as part of my Finding.

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40 Thrombocytopaenia is a decreased number of platelets in blood.
41 Transcript of evidence, p12
42 Transcript of evidence, p9
43 Transcript of evidence, p10
44 Transcript of evidence, p66

60. Mr Herrington had further concerns about the integrity of information provided to him and to the Coroners Court with respect to the circumstances surrounding Rosalie's respiratory arrest. I have considered these concerns but I am unable to find any evidence to support a contention that staff from the Royal Melbourne Hospital did not act appropriately in the circumstances.

61. Counsel for the Royal Melbourne Hospital submitted that little could have been done to predict or prevent Rosalie's respiratory arrest. They further submitted that there is no evidence that the response and resuscitation could have been preformed in a more timely or appropriate way, and in all of the circumstances, no criticism or adverse comment could be made of the Royal Melbourne Hospital in relation to the care of Rosalie King.[45]

62. All of the witnesses agreed that Rosalie's treatment was appropriate and nothing further could have been done.[46]

63. On the basis of the information available to me within the scope of the investigation as outlined by Coroner Hendtlass, I tend to agree with the submissions on behalf of the Royal Melbourne Hospital.

FINDINGS

64. I accept the cause of death as ascribed by Dr White and find that Rosalie Anne King died on 5 May 2007 at the Austin Hospital from:

    1(a) BRONCHOPNEUMONIA IN A WOMAN WITH BRAIN INJURY

65. I find that after she was struck by a car on 19 October 2006 Rosalie was conveyed to the Royal Melbourne Hospital where she was treated for her extensive injuries. She remained in the Intensive Care Unit of the Royal Melbourne Hospital until 30 October 2006 when she was then considered stable and moved to the Trauma Ward.

66. I find that on 31 October 2006 Rosalie suffered a respiratory arrest that was quick in onset and which caused a hypoxic brain injury.

67. I find that there was no clear consensus among medical witnesses as to the cause of the respiratory arrest.

68. I find that, although a pulmonary embolus was high on the list of differential diagnoses for the cause of the respiratory arrest, no evidence of an embolus was found in subsequent investigations and none of the medical witnesses were able to definitively determine or refute

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45 Submissions on behalf of the Royal Melbourne Hospital, p6

46 See for example: Transcript of evidence, p11; Transcript of evidence, p64

this hypothesis. Therefore, based upon all of the evidence, I am unable to conclude with certainty the cause of the respiratory arrest.

69. I further find that the care and management of the medical practitioners involved in both her initial treatment and her respiratory arrest at Royal Melbourne Hospital was of a high standard and consistent with standards expected of a major trauma hospital. Due to Rosalie's very sudden decline there was nothing further they could have done to prevent her from suffering the respiratory arrest and subsequent hypoxic brain injury.

70. Finally, I acknowledge the grief that Rosalie's loss has caused those who loved her. It is evident that Mr Herrington and Rosalie's parents were strong advocates for her, particularly in their efforts in furtherance of their common cultural heritage. I note, for example, that Mr Herrington indicated his preference for looking after Rosalie at home and doing everything possible to keep her alive. Although the decision to cease active treatment falls outside the scope of this Finding, I recognise the distress and difficulty that Mr Herrington and Rosalie's parents experienced due to the disjunct between their beliefs and the hospital's clinical judgement.

71. It is unfortunate that the cause of Rosalie's respiratory arrest and subsequent hypoxic brain injury may never fully be understood. I acknowledge that this might be frustrating for Rosalie's loved ones, particularly after such a long wait, however the lack of evidence means that I am simply unable to provide a definitive answer to this question.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the finding be published on the internet.

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

- Mr John Herrington
- Dr Peter Bradford, Royal Melbourne Hospital
- Ms Lynette Russell, Austin Health
- Ms Robyn Shea, Austin Health
- Ms Katie Cunnington, Clinical Risk Manager, St Vincent's Health

Signature:

Jacqui Hawkins

CORONER JACQUI HAWKINS
Date: 20 June 2014

Coroners Court of Victoria