IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001597

FINDING INTO PASSING WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	RDZ[1]
Date of birth:	12 January 2011
Date of death:	24 March 2022
Cause of death:	1(a) complications of bowel obstruction in the setting of chronic constipation
Place of death:	Royal Childrens Hospital/Flemington Rd, Parkville, Victoria, 3052
Keywords:	Paediatric, constipation, rural, Aboriginal patient

[1] A pseudonym by Order of Coroner Dimitra Dubrow to protect the identity of the deceased and his immediate family.

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INTRODUCTION

1. On 24 March 2022, RDZ was 11 years old when he passed away at the Royal Children's Hospital (**RCH**) from complications of a bowel obstruction.

2. Bowel obstructions can lead to dehydration and kidney failure. In severe cases, it can lead to bowel *ischaemia* (lack of blood supply) bowel *necrosis* (death of the bowel tissue), and death. In this case, the cause of the obstruction was a *fecalith* (hardening of faeces into stone) from chronic and refractory constipation.

THE CORONIAL INVESTIGATION

3. RDZ's passing was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. The Court was assisted by the Coroners Prevention Unit in the review of medical records, statements and other materials provided by the health services involved in RDZ's care.

7. The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

8. This finding draws on the totality of the coronial investigation into the passing of RDZ. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my

findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

BACKGROUND

9. RDZ was born on 12th January 2011 and is Aboriginal. He was the second child to his mother and father. RDZ lived with his mother, stepfather and older sister in Sale, Victoria. RDZ was in Year 5 and loved Australian Rules Football and aspired to be a professional football player when he grew up.

10. From August 2014, RDZ saw a paediatrician for his constipation. Over the following few years, the paediatrician arranged multiple admissions to Bairnsdale Hospital for management of his constipation including bowel washouts.

11. In May 2017, the paediatrician referred RDZ to a paediatric surgeon for further review and management. This review occurred in July 2017.

12. The correspondence letter from this appointment states that the plan was for RDZ to have a nuclear transit study[3] and surgical outpatient appointment at RCH. However, there is no record of this occurring from any of the medical records. RDZ does not appear to have had any further appointments with either the paediatrician or paediatric surgeon from this time.

13. On 17 March 2020, RDZ was seen by his General Practitioner (**GP**) at Gippsland and East Gippsland Aboriginal Co-Operative (**GEGAC**). At this time, he was suffering from ongoing constipation, with his mother reporting that *"constipation is regular if he doesn't have daily Parachoc[4] and Movicol[5], however when he takes those regularly, he gets faecal incontinence"*. It was noted that RDZ was *"very small and thin*".

14. RDZ's mother requested a referral to the RCH for review and management. However, the referral was rejected because the *"clinic wait time is currently over six months and we believe that with adequate management in the community, most patients' symptoms will likely improve within a few months. For these reasons, we recommend that you discuss management*

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[3] A test used to investigate the function of the colon and commonly used to assess the severity of constipation.

[4] A stool lubricant containing paraffin.

[5] A stool softener.

options with your patient". The letter provided some guidance on the management of constipation for children and links to other resources.

15. On 3 August 2020, RDZ was seen again by his GP. It was noted that *"constipation is persisting. Faecal incontinence at school when he has parachoc (4tsp) and Movicol (1 scoop)".*

16. The GP discussed dietary modifications at this appointment and suggested trying half the dose of the medications and to monitor for response. At RDZ's mother's request, he was re-referred to RCH Gastroenterology Outpatients. This referral was accepted, with a note for review within 6 to 12 months.

17. On 10 August 2020, RDZ had a follow-up phone appointment with the GP. The GP noted *"positive changes"* to RDZ's diet and that he was opening his bowels every 3rd day. They discussed further medication management.

18. On 14 July 2021, RDZ was seen for the first time at RCH by a Paediatric Gastroenterologist. The impression was *"[l]ikely severe functional constipation with inadequate maintenance therapy"*. However, due to two atypical features, being the presence of a *faecaloma* (large mass of faeces and a severe form of faecal impaction) on examination and family history of severe childhood constipation requiring surgery, the paediatric gastroenterologist considered a diagnosis of Hirschprung's Disease and planned for further investigation with surgical referral.

19. Hirschsprung's Disease is a congenital disorder of the gut caused by abnormal nerve development of the anus, rectum or sigmoid. Various sections of the gut can be affected, from small to extensive areas. It occurs in approximately 1 in 5000 births, with boys being more commonly affected than girls.

20. The majority of people with Hirschsprung's present in the neonatal period with bilious vomiting, abdominal distension and failure to pass *meconium* (first stool). For those with less severe Hirschsprung's disease, it may present later in childhood with refractory constipation.

21. Diagnosis is made by rectal biopsy which shows *aganglionosis* (no nerve cells). The definitive treatment of Hirschsprung's disease is surgery. Bowel washouts may be required in the meantime.

22. The documented plan was for a surgical referral with an abdominal Xray, blood tests, and possible admission for examination under anaesthesia, a rectal biopsy, manual disimpaction, and a nasogastric tube (**NG tube**) washout. The discharge plan was for a prolonged period of high dose laxatives with very close follow-up to adjust doses appropriately. The paediatric gastroenterologist noted that *"[t]he Aboriginal co-op is a trusted source of healthcare for this family and can help provide this close follow-up".*

23. In the meantime, RDZ was recommended for four sachets of Movicol per day. The paediatric gastroenterologist referred RDZ to the Paediatric Surgery Constipation Clinic and discussed the referral with a paediatric surgeon, who then expedited RDZ's appointment.

24. On 10 August 2021, RDZ was scheduled to see the paediatric surgeon at the RCH. However, this did not occur with the medical notes documenting *"failure to attend appointment"*. Further social work notes from that day document that the family travelled for 3 hours for the appointment but were late and missed the appointment.

25. In a statement, the paediatric surgeon outlined that by the time RDZ arrived at RCH, they were performing an emergency surgery in the Neonatal ICU and was unavailable. The on-call surgical registrar was also in the same surgery and so no one was able to see RDZ. A social worker documented that the family were *"unable to afford the cost of fuel to travel home, [mother] overwhelmed"*.

26. The family were provided with financial vouchers, information on financial supports, and details of the Vincent De Paul Welfare line. The social worker also encouraged the team to refer the family to Wadja: a *"culturally sensitive service for Aboriginal and Torres Strait Islander children and their families."*

27. Aboriginal Liaison Officers are employed in hospitals to ensure First People have equitable access to mainstream health care services, and to increase the cultural awareness and sensitivity of health care services to the distinct needs of First Peoples and their communities.

28. This referral did not occur.

29. On 18 October 2021, RDZ was seen at the next available Constipation Clinic by the paediatric surgeon via telehealth. The plan from this appointment was for an examination under anaesthesia with a rectal biopsy and to continue with Movicol.

30. The paediatric surgeon stated that they were due to start a period of extended leave and wanted to perform the procedure and so arranged for the procedure to be delayed until after their return on 1 February 2022. The paediatric surgeon believed that RDZ's presentation with chronic constipation was not uncommon and was safe to be delayed until this time. The procedure was booked as a Category 2 from the date of his return from leave.

31. On 23 February 2022, RDZ was seen again by the paediatric gastroenterologist at RCH via telehealth. It was noted that he was still on the waiting list and that his laxative regimen was 1-2 sachets of Movicol per day plus Parachoc. It was noted that RDZ had tried four sachets of Movicol as recommended and stopped Parachoc during this time. He found defecation too painful and would withhold passing stools. The Xray and blood results were the same as previous and showed normal blood results and constipation on Xray.

32. The paediatric gastroenterologist stated that given these results and that RDZ had been in the same stable pattern for many years, an emergency admission to RCH was not required and RDZ was safe to wait for the elective surgical admission.

33. The plan in the meantime was to increase the Parachoc and Movicol and that it *"[m]ay be worth considering an admission in Sale for conscious sedation, NG insertion, enema and slow washout with Glycoprep[6] 2 litres per day. This may then allow maintenance medication to be more effective as well as making it more possible to address fear of defecation by hopefully slowly reducing the large faecaloma".*

34. Local admission was not arranged at that time.

35. On 1 March 2022, RDZ was seen by a gastroenterology fellow who then discussed the case with the paediatric gastroenterologist. This clinic review noted that RDZ was taking four Movicol sachets and Parachoc each day. He remained mostly incontinent but was passing sludgy stool daily and was a bit more comfortable and less distended. He was advised to continue the same treatment for two more weeks then to see his GP after this to determine subsequent management. A follow-up appointment was scheduled for 19 April 2022.

[6] An osmotically acting laxative commonly used prior to colonoscopy.

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

Circumstances in which the death occurred

36. On 23 March 2022, RDZ presented to his GP with his mother. Notes from this consultation document worsening of his constipation. RDZ normally took two sachets of Movicol and two tablespoons of Parachoc per day, but the family had run out of Parachoc one week prior. Annotated handwritten notes from the GP's referral letter to RCH state that *"the family can't afford any picolax[7] or parachoc at present which is why it developed into significant faecal loading".*

37. RDZ was having faecal incontinence through the day and night, and having generalised abdominal pain, which was worse at night-time. The GP noted he had a grossly distended abdomen, but that bowel sounds were present. The GP spoke with the Emergency Department Admitting Officer and advised for the family to present to hospital, with a plan for likely enema and picolax.

38. At 4.24pm, RDZ arrived at Bairnsdale Hospital Emergency Department and was triaged at the Bairnsdale Hospital Emergency Department was allocated a triage category 3.[8] Nursing assessment documentation noted that RDZ was *"sent by GEGAC for refractory constipation"*, had not opened his bowels for several weeks, had a distended abdomen, had abdominal pain and nausea, and that this was an ongoing issue and he was on the waiting list at RCH.

39. RDZ's temperature was documented as 35.4 degrees, indicative of hypothermia. No other vital signs were taken at triage.

40. At 6.33pm, RDZ's vital signs were documented on his chart. His oxygen saturations were 100% (normal), heart rate was 150bpm (very high), respiratory rate was 38 (high), was in mild respiratory distress, and had a pain score of 4-7. No temperature or blood pressure was documented at this time.

41. An entry at 6.44pm noted that RDZ was in treatment room 1[9] with his mother. RDZ was documented as *"[s]tanding beside bed, moving around appearing uncomfortable.*

[7] A combination of medications in a single preparation commonly used prior to colonoscopy to clear the bowel. It is indicated in severe constipation.

[8] The Australasian Triage Scale (ATS) is a clinical tool used to establish the maximum waiting time for medical assessment and treatment of a patient. ATS 3 should have a maximum waiting time of 30 minutes.

[9] RDZ was taken here as it was the first available cubicle in the ED. The treatment room is not a monitored room and is not appropriate for acutely unwell patients.

Obs[ervations] done. Increased RR and HR." RDZ was *"unable to state how bad pain was just stating in hurts"*. RDZ required assistance to move up the bed and was subsequently moved to a resuscitation bay.

42. Medical notes document that RDZ *"looks unwell, dehydrated"*, his abdomen was *"extremely distended"*, with *"very sluggish bowel sound"* and *"tender to deep palpation"*.

43. After discussing with a Senior Medical Officer, a decision was made for RDZ to have blood tests and intravenous therapy. Blood tests he had a lactic acidosis and elevated white cells of 18.9. An abdominal Xray showed *"massive bowel loop distension mainly large bowel loaded with faecal impaction"*.

44. At 7.09pm, RDZ's case was referred to the Paediatric Infant Perinatal Emergency Retrieval service (**PIPER**). The plan was for RDZ to be transferred to RCH, and to receive intravenous fluids, triple antibiotic therapy (amoxicillin, gentamicin, metronidazole), a nasogastric tube, and blood tests, including blood culture, in the meantime.

45. No blood pressure recording is documented in the medical records throughout RDZ's entire stay in the Bairnsdale ED.

46. RDZ was transferred with PIPER to RCH and arrived at the ED just after midnight, 24 March 2023. He was documented as being severely unwell, shocked, drowsy and with a surgical abdomen.[10] His lower extremities were cool, with dilated veins. It was thought he was in shock secondary to abdominal compartment syndrome.

47. RDZ required supplemental oxygen, IV glucose due to hypoglycaemia and was given antibiotics and further fluids. He was seen by the surgical team who decided he needed emergency abdominal surgery involving a laparotomy with possible bowel resection and stoma.

48. RDZ was stabilised and transferred to the operating theatre for surgical management with the on call paediatric surgeon. In surgery, it was found that RDZ had faecal impaction of the rectum and sigmoid colon with a very large fecalith and resultant megacolon.[11] There was significant bleeding in the second half of the procedure.

[10] A surgical abdomen means there is a pathology that likely needs surgical management.
[11] Extreme abnormal distension of the colon.

49. Following the surgery, RDZ was admitted to the Paediatric Intensive Care Unit (**PICU**). RDZ's previous paediatric surgeon was notified of his admission and attended to him with the on call paediatric surgeon.

50. RDZ had significant coagulopathy, acute liver injury, acute kidney injury, multiple electrolyte derangements, and required significant intensive care supports, including intubation and ventilation and inotropes.[12] RDZ required multiple blood products to address the coagulopathy, but it was noted that *"bleeding continued to be difficult to control during time in PICU"*.

51. At around 9.37am, RDZ went into cardiopulmonary arrest in the context of hyperkalaemia,[13] and required CPR. At 9.39am, RDZ had a Return of Spontaneous Circulation (**ROSC**).

52. At 9.45am, the surgical team reviewed RDZ's dressings and noted that there was *"no obvious surgical bleed evident"*. RDZ had a further brief period of CPR due to bradycardia and was urgently taken back to the operating theatre due to concerns of progressive gut ischaemia.

53. In the operating theatre, RDZ was commenced on haemodialysis for his acute kidney injury. During the emergency surgery, it was noted that he had a significantly dilated and oedematous colon and small bowel with abdominal compartment syndrome.[14]

54. Both paediatric surgeons were present and released the pressure from RDZ's previous dressing, removed his large bowel, confirmed the presence of nerve cells in the small bowel being preserved, created a small bowel stoma and left his abdomen open in preparation for his return to PICU.

55. A frozen section of sigmoid biopsy was sent for pathology review, which was later analysed and demonstrated *hypoganglionosis* (reduced nerve cells).

56. At 1.40pm, RDZ returned from the operating theatre to PICU. His surgical abdominal wound had been left open to relieve the pressure of compartment syndrome. RDZ continued to have significant bleeding in the drains and diffuse oozing from the bowel. He required multiple inotropes to maintain his blood pressure.

[12] Medications to support blood pressure.
[13] Elevated potassium in the blood, an electrolyte.
[14] Abdominal compartment syndrome occurs when the pressure in the abdominal cavity is abnormally elevated. It is a medical emergency and is associated with multiorgan dysfunction.

57. The intensive care doctors discussed the case with the haematology team to manage the coagulopathy and the massive transfusion protocol[15] was commenced. The surgical team advised that no further surgical interventions were possible.

58. At 3.02pm, RDZ had a further cardiopulmonary arrest in the context of his ongoing bleeding, severe coagulopathy, hypotension and bradycardia. Despite maximal interventions and resuscitative efforts, RDZ passed away at 3.30pm.

59. Wadja Aboriginal Family Place case managers were involved in supporting RDZ's family through his brief admission at RCH and following his passing.

Identity of the deceased

60. On 24 March 2022, RDZ, born 12 January 2011, was visually identified by his mother, who completed a statement of identification.

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

Medical cause of death

62. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 30 March 2022 and provided a written report of the findings.

63. The autopsy did not identify an overt bleeding point and showed generalised ooze and clot material overlying the bowel. There was evidence of multi-organ failure. Histological examination (examination of tissue under the microscope) showed hypoganglionosis of the bowel.

64. Toxicological analysis of ante-mortem samples identified the presence of medications administered in hospital. Analysis of post-mortem samples identified the presence of methylamphetamine and ketamine in the hair but not in the blood. Dr Ho commented that this can occur during environmental exposure.

65. Dr Ho provided an opinion that the medical cause of death was *1(a) complications of bowel obstruction in the setting of chronic constipation* and that the death was from natural causes.

[15] Rapid administration of large amounts of blood products for the management of haemorrhagic shock.

66. I accept Dr Ho's opinion. While the presence of drugs in the hair is obviously concerning, they are non-contributory to the death and so I have not investigated this further.

ORGANISATION RESPONSES

67. RCH and Bairnsdale Regional Health Service (**BRHS**) both reviewed RDZ's case. The outcomes were included in the various statements provided to the Court from these organisations.

Bairnsdale Regional Health Service

68. The Chief Medical Officer (**CMO**) outlined the various areas in which hospital policy was not correctly followed at the time of RDZ's presentation. These included an incomplete triage assessment, inadequate observations after triage, and lack of blood pressure being recorded throughout RDZ's presentation. The CMO also outlined other findings including use of unmonitored waiting room spaces, delay in antibiotic administration, and issues with the review process itself.

Incomplete triage assessment

69. A complete vital signs assessment at Triage is required in accordance with the Referral Procedure for Neonatal and Paediatric presentations to Emergency Department. The nursing entry for RDZ's assessment at triage in the EMR includes Temperature only being recorded.

70. The ATS 3 assessment was noted in the absence of a full vital signs assessment, this being contrary to hospital policy. Paediatric physiological discriminators were not documented at Triage. The ATS Category 3 was applied in the absence of a complete assessment of vital signs in accordance with the Victor Chart and Referral Procedure for Neonatal and Paediatric presentations to Emergency Department.

Inadequate observations performed after triage

71. The Emergency Department Guide requires a full set of observations to be performed at least half-hourly for all patients' triages with ATS Category 1, 2 or 3.

72. The BRHS policy regarding frequency of observations in a resuscitation area was not followed. Documentation on the Victor Chart confirms incomplete vital signs recorded at 6:33pm, 7:00pm, and 9:15pm. Observation and assessment was documented and includes

oxygen saturation levels, respiratory rate, respiratory distress, heart rate, temperature, level of consciousness, and pain score. Blood pressure was not recorded on the Victor Chart.

Lack of blood pressure being recorded throughout entire presentation.

73. Blood pressures should be taken and recorded for unwell children and is a required field on the Victorian Children's Tool for Observation and Response in Urgent Care, otherwise known as the Victor Chart.

74. There is no documented evidence recorded that RDZ's blood pressure was measured either on initial assessment at Triage or on the Victor chart throughout RDZ's stay in ED. The absence of a recorded blood pressure in RDZ's record (either EMR or MR) is unexplainable when reviewing RDZ's records.

75. The CMO identified that the nursing orientation handbook has been updated as the previous version was outdated and contained inconsistent procedures for managing paediatric cases.

Use of the Warrawee Room

76. The CMO outlined that RDZ's family elected to use the Warrawee Room while waiting to be seen in the ED. The Warrawee Room is a place for Aboriginal patients, family, and health workers to use. However, this room is unmonitored and is not within the line of sight of the triage nursing station.

77. The CMO stated that:

"Upon review, there was no procedure to guide the safe use of the Warrawee Room. Since this incident, a guideline for the use of the Warrawee Room was developed by the BRHS Aboriginal Health Unit in close consultation with the Indigenous community. The guideline includes clinical criteria to exclude the use of Warrawee Room, and if the Warrawee Room remains the patient's choice, then recommended reassessment timeframes are also included."

78. The associated safe use of the Warrawee Room document outlined that the room is not recommended for ATS category 1-3 patients.

Delay in Antibiotic Administration

79. The antibiotic amoxicillin was charted but not administered to RDZ. There was a review of the timing of antibiotic administration which suggested that antibiotics which can be

administrated quickly should be administered first. This has been communicated with nursing staff.

Review Process

80. The CMO stated that BRHS did not report the case to Safer Care Victoria as a Sentinel Event because the death occurred at RCH. This is in keeping with advice from SCV that the *"health service that provided the final care related to the adverse event should be responsible for notifying the event, initiating the review and engaging the other health services."*[16] Instead, an initial case review was performed by the Deputy Director of Medical Services following RCH notifying BRHS of RDZ's passing.

81. This initial review did not identify significant concerns with the medical management. This is inconsistent with the identified deviations from hospital policy. When asked to clarify this apparent inconsistency, the CMO stated that the review focused on the medical management only and that these systems issues were not appreciated until they were discovered following the RCH Root Cause Analysis (**RCA**, discussed below). BRHS were involved with the RCH RCA as also recommended by SCV that *"[a]ll services involved in the care of the patient should participate in the review."*[17]

82. The CMO stated that since this time, further reflections and changes have been made around the *"overreliance on the Deputy Director of Medical Services to quickly triage incidences".* BRHS now has a Clinical Safety Huddle which occurs twice weekly. *"Clinical incidences are discussed at this Huddle to determine if a particular incident meets certain criterion for SAPSE, Open Disclosure, Incident review etc. Membership for this huddle includes the Safety and Quality team, executives of all clinical areas, and senior managers."*

83. The case was also discussed at the ED Morbidity and Mortality (**M&M**) meeting on 16 August 2023. The decision was made to delay the ED M&M review and discussion until the medical examination report was available to identify the cause of RDZ's passing. This is no longer the case and BRHS M&M meetings no longer wait for this report before reviewing and discussing a case.

84. This case discussion also identified that access block contributed to RDZ breaching triage wait time. This occurs when there is a significant number of patients in the ED waiting to be

[16] SCV website, Notify and review a sentinel event, available at: <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/notify-and-review-a-sentinel-event>
[17] Ibid.

admitted to the ward which prevents new patients from being admitted to an ED bed. This causes a backlog of patients in the waiting room and ramped ambulances.

Royal Children's Hospital

85. The CMO outlined RCH's strategies, policies and procedures for the provision of culturally safe and responsive health services to Aboriginal and Torres Strait Islander patients. They also outlined the availability of Aboriginal and Torres Strait Islander health professionals at RCH including the Wadja Health Clinic.

86. I consider that the RCH strategies and resources available to provide health care to Aboriginal and Torres Strait Islander patients appear to be of a high standard. Unfortunately, it appears that these standards were not met in this case.

87. The CMO outlined that there was no firm clinical indication for hospital admission for RDZ's chronic constipation, and that given the noted trusted relationship with the GEGAC service, it was reasonable that if non-surgical admission were to be considered, it would be at a local regional hospital.

Missed appointment on 10 August 2021

88. The CMO stated that:

"It is unfortunate that RDZ was not able to be seen for his surgical appointment on 10 August 2021. The RCH acknowledges that contact in advance of his appointment by an RCH employee or a member of RDZ's local treating medical team at GEGAC might have supported RDZ and his family to enable arrival at the appointment with sufficient time for him to be seen. Whilst the RCH does aim to make such pre-appointment contact with as many identified Aboriginal or Torres Strait Islander outpatients as possible, unfortunately this cannot occur for every outpatient and family.

In addition, had RDZ been referred directly to the Wadja service on 10 August 2021, subject to availability, a Wadja Case Manager may have been able to:

A. Provide RDZ and his family with support, resources and advocacy services while he was still in attendance at the RCH and provide a point of contact for the family going forward. Unfortunately, given surgical resources on the day, it appears unlikely that RDZ would have been able to attend a surgical consultation that day following the late arrival; or

B. Sought to have arranged for the family to have stayed overnight in Melbourne in order for them to have been seen by a clinician at the RCH the following day. This is not standard practice, but something that may have been considered in the circumstances.

The RCH acknowledges that the above opportunities for culturally sensitive care were not provided to RDZ."

Delay in examination under anaesthesia

89. This did not occur prior to RDZ's passing. The CMO stated that:

"I understand there were multiple contributing factors that caused the period of time between RDZ's initial appointment with [the paediatric surgeon] and his passing on 24 March 2022, including:

A. During 2021/22 all RCH surgeons were managing long waitlists. The impact of COVID-19 was significant, and it meant that health services were under pressure during this period. A statewide Pandemic Code Brown was announced in January 2022 across all Victorian public hospitals, including restrictions on elective surgery during this time.

Between August 2021 and March 2022, the RCH elective surgical waitlist increased significantly. This was consistent with there being increases in all waitlists across the RCH during the same period. The long waitlists resulted in increased wait times for patients throughout the RCH. It was common for surgery wait times to be breached during this period and patients within each waitlist category were being prioritised by the degree to which they had breached their wait time.

B. There was a limited ability to obtain locum assistance during the 2021/22 period generally and particularly in an area of subspecialty interest. At least in part, this was also due to COVID-19. A backfill locum was employed by the RCH to cover [the paediatric surgeon's] leave of absence. However, the locum was not able to commence at the RCH until approximately the same time that the paediatric surgeon returned from leave in January 2022.

C. As an alternative to placing RDZ on the Category 2 waitlist, it may also have been an option for RDZ to have been placed on a Category 3 waitlist. This could have resulted in a wait period of up to or over 12 months. Rather, RDZ was placed on a Category 2 surgical waitlist with the wait period to commence from the end of January 2022. I note that as of 30 June 2022, the data reported for the preceding quarter provided that the RCH average overdue wait

time for category 2 patients was 148.46 days and the average overdue wait time for category 3 patients was 231.65 days. This data is reported in relation to each Victorian public hospital via the Victorian Agency for Health Information website.

The above factors appear to have contributed to RDZ's case not being transferred to another specialist during the period of leave, along with [the surgeon's] preference to perform the surgery himself.

Given the above combination of factors and noting RDZ's presentation on 1 March 2022, it remains uncertain whether he would have been admitted for surgery earlier even if he was seen by [the paediatric surgeon] on 10 August 2021, or if he was transferred to another surgeon during [the] leave of absence.

Sentinel Event Review

90. The Findings of Sentinel Event Review were also detailed in the CMO's statement. These were:

A. The regional and remote location of the patient meant that regular review by a paediatrician was difficult.

B. The lack of structured links and communication pathways between RCH, GEGAC and the other primary health services meant the vulnerability of this patient was not identified by the RCH.

C. There is a lack of shared understanding about health services and capability which meant the vulnerability of this patient was not identified and appropriate services linked to the patient pathways.

D. There are no systems of governing bodies that allow for the sharing of state-wide paediatric services which maximises access to services for children across all regions of Victoria.

91. Four recommendations were made following the case review process. All the recommendations for which RCH has control have been fully implemented:

a) Implement a vulnerability section on the GEGAC medical/health referral form which can easily identify vulnerability for other health providers.

"As this recommendation relates to a change to GEGAC's referral form the recommendation has been allocated to GEGAC for implementation. It is not currently known whether the recommendation has been implemented by GEGAC. It is otherwise noted that the RCH Specialist Clinics Referral form already includes space for flagging of patients identifying as Aboriginal or Torres Strait Islander."

b) Advocate to Safer Care Victoria for the reinstatement of the paediatric network (however named) with the purpose of sharing information and services for children and young people.

"In December 2022, the RCH submitted a proposal and capability plan to SCV for a statewide paediatric network. RDZ's case was also shared with the RCH Clinical Quality and Safety Committee to highlight the need to advocate for the development of a state-wide paediatric plan and paediatric capability framework.

*The RCH CEO, along with other Victorian hospital CEOs advocated strongly for the Victorian Paediatric Clinical Network (**VPCN**) to continue. Pleasingly this has recently been re-established as a partnership agreement between Victorian hospitals and health services responsible for delivering paediatric care.*

A VPCN Clinical Lead and Network Manager have been appointed and the VPCN is in the process of finalising its membership and establishing its Steering Committee. The VPCN has been established to improve health care for children and young people in Victoria. The collective expertise of the VPCN will seek to identify and address quality and safety issues impacting the Victorian paediatric service system and support the delivery of safe, effective, accessible and equitable health care for the benefit of all children, young people and their families.

The VPCN is expected to have a particular focus on promoting connected care and developing a coordinated statewide model of care for paediatrics in Victoria."

c) Establish links between GEGAC and Wadja (RCH) so that vulnerable regional consumers can be linked between services.

"Members of the RCH Wadja team already hold strong links and relationships with various ACCHOs, including GEGAC. Following RDZ's passing and in working towards this recommendation, more formal links have been established. Although, it is noted that such relationships within the community may operate best when they are maintained with a less

formal approach to building trust and rapport over time. The Wadja team are in regular contact with GEGAC for follow up and care on a case-by-case basis as required for RCH and GEGAC shared patients."

d) Add to the roadmap of the Specialist Clinics transformation and redesign team, the need to examine telehealth opportunities so that regional health centres can include GPs in telehealth calls.

"The need to examine telehealth opportunities so that regional health centres can include GPs in telehealth calls has been added to the Specialist Clinic Roadmap (Roadmap). The Roadmap sets out a pathway for the RCH to transform the current specialist clinic service to best meet the diverse needs of RCH patients and families.

The Roadmap includes the following actions:

"Support patient care in the community - Link with the projects underway within the organisation that focus on supporting and educating GPs to keep patients in the community. Leverage the learnings and implement best practice models to coordinate and connect with primary healthcare providers."

"Telehealth opportunities - The digital boom related to COVID-19 and the push to Telehealth appointments has created a great opportunity to review our current practices for the benefit of the patients and the organisation. Review support for ongoing Telehealth practices and support flexible Telehealth practices."

The estimated time for completion of the project is 3-5 years from commencement at the beginning of 2023. However, the work being done is already having an impact with a reduction in the specialist clinic waitlists from 14,000 patients to 4,000 patients over the last 8 months."

92. The CMO also outlined other relevant developments that have occurred at the RCH since RDZ's passing:

"A. Creation of a part-time Paediatric Wadja Clinical Lead as the first dedicated clinical resource within Wadja.

B. Wadja has moved into the division of medicine, creating a visible footprint within the division enabling enhanced connectivity across the RCH.

C. The RCH CEO has been appointed co-chair of the Aboriginal Advisory Committee ensuring senior executive support and oversight for the important work of the committee.

D. The RCH elective surgical waitlist has reduced since March 2022, consistent with a reduction in waitlists across the hospital, as services gradually recover from the impacts of COVID-19."

93. The CMO concluded that:

"the RCH has thoroughly reviewed and considered the circumstances surrounding RDZ's passing. Many contributing factors shaped the timeline of events. I accept that RDZ's level of vulnerability may not have been entirely appreciated within the RCH or his community healthcare providers. The support and communication offered to RDZ and his family by both the RCH and his community healthcare providers, in light of such vulnerabilities, could have been better."

Hypoganglionosis and Hirschsprung's Disease

94. The paediatric gastroenterologist noted that the hypoganglionosis was discussed in an RCH histopathology meeting. It was discussed that the exact significance of this was unclear; it could either be the primary cause of RDZ's constipation or from stretching of the bowel from long-term constipation. This is an "incredibly rare" complication of chronic constipation.

95. The literature also demonstrates that hypoganglionosis is a rare cause of chronic constipation. The RCH EMR documents a family meeting discussion on 31 August 2022. These notes state:

"The samples sent from theatre show reduced but not absent ganglion cells which are not a definitive diagnosis of Hirschsprung's but would explain his chronic constipation…this severity of illness is a most unusual complication of his underlying constipation, and [may not] have been predicted / prevented from occurring."

96. Ultimately, I consider that whether the underlying cause of RDZ's refractory constipation was due to congenital hypoganglionosis or undertreatment can never be known. Regardless, this case demonstrates gaps in provision of culturally appropriate care to a vulnerable Aboriginal boy who had unusual and severe complications of chronic constipation.

COMMENTS

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

1. The evidence does not support a finding that RDZ's passing was preventable had he received optimised care on 24 March 2022. By this time, it was too late for interventions to meaningfully change the outcome.

2. However, the passing of a child from bowel obstruction in the setting of chronic constipation is preventable in the sense that constipation can and should be treated before it progresses to the stage of bowel obstruction. There were various aspects of care provided to RDZ that were suboptimal and the contributing factors in RDZ's passing were multifactorial and include:

    a) Missed opportunities to provide culturally appropriate care and supports

    b) The challenges in health care coordination for a rural and vulnerable Aboriginal child

    c) Limited supports and links with tertiary care for rural healthcare workers in Aboriginal Health Services

    d) The impacts of the COVID-19 pandemic on surgical waitlist times.

    e) The importance of full vital sign assessment (including BP) for paediatric patients presenting to Emergency Departments, both at triage and whilst awaiting medical assessment

    f) The importance of ongoing monitoring of patients in ED waiting rooms after initial triage

3. I am satisfied that the areas in which the care of RDZ could have been optimised have largely been covered by the RCH led Sentinel Event Review and have mostly obviated the need for coronial recommendations. An additional issue which I have considered are the costs of medications for constipation.

Financial Burden of Medications

4. In addition to the above broad considerations, I also consider that a key precipitating factor for RDZ's deterioration on 24 March 2022 was the financial burden of medications for constipation, particularly the cost of Parachoc. It appears that financial strain was a factor throughout this case. I note that this class of medication for constipation is not listed on the Pharmaceutical Benefits Scheme (**PBS**). I also note that Movicol, another one of RDZ's regular medications, is listed on the PBS.

5. The PBS lists the details of medicines subsidised by the Australian Government. As of 1 January 2024, patients may pay up to $31.60 for most PBS medicines, or $7.70 with a concession card up. Once a patient reaches the PBS Safety Net threshold, there is no charge for medicines for the remaining calendar year. The threshold is currently $277.20 for concession card holders and $1,647.90 for other eligible patients.[18]

6. Medicines are added to the PBS by the Minister for Health on the recommendation of the Pharmaceutical Benefits Advisory Committee (**PBAC**). While there are specific procedures to apply for a medication to be considered by PBAC, anyone can bring issues to the attention of PBAC for their consideration.[19] The recommendation I have made below, if implemented, starts the process for adding Parachoc to the PBS in line with the use of Movicol for use in chronic and refractory constipation.

Review process at BRHS

7. I acknowledge that since RDZ's death some changes have been made to BRHS policy and procedure to improve care for paediatric patients in the ED. However, the updated ED orientation still provides limited information on management of paediatric presentations and instead refers to a separate guideline. This other guideline states that BP should only be *"considered in older children or an unwell infant"* rather than requiring the performance of BP as part of a vital signs assessment. I consider that performing a BP measurement should be equally important in infants and children of all ages and I note that the ViCTOR chart contains BP as a core vital sign.

8. There is reference in the CMO's statement to 'performance management' of staff. I note that while there is a place for 'performance management', this is a separate process to a root cause analysis or other systems review process which should instead focus on the best preventative measures for sufficient safety netting, guidelines and inbuilt systems to support clinicians, minimise mistakes and ensure prompt recognition and correction of errors.

FINDINGS AND CONCLUSION

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

[18] Figures according to the PBS website: https://www.pbs.gov.au/info/about-the-pbs (last updated 7 May 2024).
[19] Procedure guidance for listing medicines on the Pharmaceutical Benefits Scheme, *Department of Health and Aged Care*, 4.1.7 General correspondence to the PBAC. Available at https://www.pbs.gov.au/info/industry/listing/listing-steps (last updated 21 December 2022).

a) the identity of the deceased was RDZ born 12 January 2011;

b) the death occurred on 24 March 2022 at Royal Childrens Hospital/Flemington Rd, Parkville, Victoria, 3052, from *complications of bowel obstruction in the setting of chronic constipation*; and

c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation

(i) That the Pharmaceutical Benefits Advisory Committee consider liquid paraffin and/or other lubricant laxatives for recommendation to be added to the Pharmaceutical Benefits Scheme for use in chronic constipation or faecal impaction not adequately controlled with first line interventions such as bulk-forming agents.

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

Pursuant to section 73(1A) of the Act, I order that a de-identified version of this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

RDZ's mother
RDZ's father
Gippsland and East Gippsland Aboriginal Cooperative
Bairnsdale Regional Health Service
The Royal Children's Hospital
Fitzpatrick House
Safer Care Victoria
Department of Families, Fairness and Housing
Consultative Council on Obstetric and Paediatric Mortality
Commission for Children and Young People

Signature:

Coroner Dimitra Dubrow

Date : 22 November 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.