MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

# Record of Investigation into Death (Without Inquest)

*Coroners Act* 1995

*Coroners Rules* 2006

*Rule* 11

I, Simon Cooper, Coroner, having investigated the death of RS,

**Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that**

a) The identity of the deceased is RS;

b) RS died in circumstances set out further in this finding;

c) The cause of RS' death was infarction and volvulus of the small intestine; and

d) RS died, aged 19 months, on 10 June 2021, at the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into RS' death. The evidence includes:

- Tasmanian Health Service – Death Report to Coroner;
- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Sudden Unexpected Death in Infancy Checklist;
- Post Mortem Report – Dr Christopher Lawrence, Forensic Pathologist;
- Medical report – Dr Anthony J Bell, Medical Advisor to the Coronial Division;
- Affidavit – SJ, sworn 6 July 2021;
- Précis of medical records – Ms L Newman, Clinical Nurse Specialist; and
- Medical Records – Tasmanian Health Service.

## Introduction

RS was born on 18 October 2019 at the Launceston General Hospital, the daughter of SJ and JD.

She had a significant medical history, being diagnosed with a large Wilms tumour (a cancerous kidney tumour) which necessitated a radical right nephrectomy and chemotherapy. But she was progressing well until June 2021.

**Circumstances of death**

During the night of 8 or 9 June 2021 RS became unwell, suffering pain, lethargy and vomiting. SJ contacted her general practitioner who advised her to rehydrate RS and, in the event that that was unsuccessful, to take her to hospital. SJ followed that advice but RS' vomiting did not abate and accordingly she took her daughter to the Launceston General Hospital arriving there in the early hours of 10 June 2021.

Upon presentation it was immediately evident that RS was gravely unwell. She was triaged as category two, to be seen in 10 minutes.

A Children's Early Warning Tool (CEWT) was carried out and returned a score of six (6). The actions required to be taken as a result of that score were:

- Notification of the team leader;
- Senior doctor review within 15 minutes;
- Complete observations a minimum of every 15 minutes;
- Notification of the inpatient team; and
- In the event of a failure to improve, immediate notification to a senior medical officer or consultant.

In fact, RS' medical records suggest that none of this was done. For example her first recorded clinical observations are at 2.20am. Instead, RS was initially treated in the waiting area and attempts at rehydration before she was moved to the hospital's ED short stay area around 3.00am.

RS' records indicate she was first reviewed by a doctor at around 4.21am when she was reviewed in the short stay area by an ED registrar (it is possible that she was reviewed by a doctor earlier but if she was it is not recorded in her medical records).

At 4.45am RS was reviewed by a paediatric registrar. At this time her records indicate a small bowel obstruction was suspected and vascular access unable to be obtained. A nasogastric tube was inserted but pulled out (by RS) and then reinserted.

At about 6.00am (although the medical records are somewhat imprecise as to times) the paediatric consultant arrived to examine RS. Medical imaging was requested but was not carried out for another hour or so. Imaging did not show evidence of any bowel obstruction.

Clinical observations are recorded as having been taken at 7.50am, over five hours after they were last recorded as having been taken.

At 8.15am an intraosseous cannula was inserted and a bolus of 250 ml of fluid was able to be administered. RS' medical record indicates she was febrile with a heart rate of between 200 and 210 beats per minute, a respiratory rate of 50 breaths per minute and oxygen saturation 94% on ambient air. Her stomach was distended.

Blood tests showed RS to be suffering acute renal failure as well as elevated haemoglobin and white blood cells. Her imaging was reviewed by paediatric surgeons at the Royal Hobart Hospital (RHH) and decision made for her urgent transfer to the RHH by road ambulance.

RS arrived at the RHH at 1.46pm and transferred directly to the hospital's paediatric intensive care unit (ICU). By now RS was in shock and multi-organ failure. ICU support measures were commenced with a plan for immediate abdominal surgery. However, RS continued to deteriorate and died.

**Investigation**

The fact of RS' death was reported in accordance with the requirements of the *Coroners Act* 1995. Her body was formally identified and then transferred to the hospital mortuary. At the mortuary an autopsy was performed by experienced forensic pathologist Dr Christopher Lawrence. Dr Lawrence provided a report in which he expressed the opinion that the cause of RS' death was infarction volvulus of the small intestine due to an adhesion of the lower part of her small intestine. The fibrous adhesion in turn was attributable to surgical removal of the tumour. I accept Dr Lawrence's opinion.

In light of the circumstances in which RS died, her death was investigated by the Coronial Division Medico-Legal committee. That investigation involved obtaining her medical records, analysing those records and a review by the Medical Advisor to the Coronial Division, Dr Anthony J Bell. All of that information and material has informed this finding.

**Conclusion**

I am quite satisfied that the care and treatment RS received after her transfer and admission to the Royal Hobart Hospital was of an entirely appropriate standard.

However, the same cannot be said of the treatment and care RS received at the Launceston General Hospital. Specifically, delays associated with an accurate diagnosis of bowel obstruction meant in turn RS' necessary transfer to the Royal Hobart Hospital was delayed.

I consider that the evidence is plain that the failure to make that diagnosis was the result of a failure to adhere to any of the procedures mandated as a result of the score returned by the completion of the CEWT.

I consider that the failure to transfer RS to the Royal Hobart Hospital earlier may have been the difference between her survival and death.

These findings were sent in draft to the Launceston General Hospital with an invitation to comment or provide additional information. The LGH acknowledged that RS' death was a terrible tragedy and extended condolences to her whole family. Further, the hospital informed that a review of RS' treatment had been undertaken with a view to "identify system improvements and learning opportunities to prevent an event of this type occurring the future".

However, I did not understand any of the findings contained in this finding to be in dispute and I therefore proceed therefore on the basis that nothing in this finding is in fact in dispute.

**Comments and Recommendations**

The circumstances of RS' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of RS.

**Dated** 03 April 2023 at Hobart in the State of Tasmania.

**Simon Cooper**
**Coroner**