IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4815

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**CHILD W**
Date of birth:	2 June 2001
Date of death:	25 December 2011
Cause of death:	Ischaemic Large Bowel; Large Bowel Obstruction secondary to Chronic Constipation
Place of death:	Peninsula Health (Frankston Hospital), 2 Hastings Rd, Frankston, Victoria
Catchwords:	Unexpected child death

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HER HONOUR:

BACKGROUND

1. Child W was born at the Frankston Hospital on 2 June 2001. Her mother, Ms W, was 22 years old when she gave birth to Child W, her first child.

2. Child W's father lived with Ms W and her family until one week after Ms W found out that she was pregnant. They have not spoken since.[1]

3. From the time of her birth and up until her death, Child W had problems with going to the toilet and passing stools. At four months of age, Child W was chronically constipated. By the age of three, Child W was toilet trained for urinating, but she never passed stools in the toilet. Whenever Ms W took Child W to the toilet to get her to pass stools, Child W would hold the stools in and say that she did not need to go.

4. In 2006, when Child W was four years old, she commenced Kindergarten at the Lyrebird Pre School in Carrum Downs.[2] Child W would refuse to go to the toilet whilst at Kindergarten, and she would hold on until she got home and then soil her pants. Child W told her mother that she could not go to the toilet because it hurt and that she was always scared of passing stools.[3]

5. In 2006, Ms W commenced a relationship with Mr H, who is 19 years older than she is, and had two teenage children from a previous relationship. In January 2007, Ms W and Child W moved out of the family home and moved into another residence in Frankston, with Mr H and his 16 year old son.

6. In 2008, when Child W was in Grade 1, she started soiling herself at school on an almost daily basis.[4] The School would change her and send her dirty clothes home. The School arranged parent teacher meetings with Ms W in relation to this matter, and told Ms W to take Child W to see a doctor.[5]

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[1] Coronial Brief, statement of Ms W, pge 23. All references to statements throughout this finding are references to documents within the Coronial brief.
[2] *Ibid.*
[3] *Ibid*, pge 26.
[4] *Ibid*, pge 28.
[5] *Ibid.*

7. On 16 September 2008, Ms W took Child W to Dr George Maragoudakis (**Dr Maragoudakis**) at Parkside Doctor in Frankston, in relation to Child W's soiling problem. Dr Maragoudakis conducted a clinical examination of Child W and the results were normal. He then had a long counselling session with Child W[6] where he spoke to her and her mother about her condition, called encopresis. Dr Maragoudakis noted that it was his impression that Ms W and Child W understood the issues associated with Child W's condition. He made a note of the fact that he asked to see Child W again in two weeks. His notes indicate that no follow up appointment was made for Child W at that time.[7]

8. In February 2009, Ms W gave birth to a baby girl.[8] Child W was thrilled about having a sister and the birth did not have any adverse effect on her behaviour.

9. During 2008, 2009 and 2010, Ms W often had to pick up Child W from the School because she had soiled herself. Ms W would take her home, bath her and then take her back to school.[9]

10. On 15 July 2010, Child W again attended Dr Maragoudakis in relation to her soiling issues. She presented on that occasion with constipation. Clinical examination showed that Child W was slightly bloated, lax, and non-tender.[10] Treatment on this occasion consisted of fluids, fibre, fruit and vegetables, and Movicol half, twice daily.[11] Dr Maragoudakis' recommendation was that if Child W was not a lot better in 1-2 days, then she should be brought back to see him. Neither Child W nor her family attended Dr Maragoudakis' practice again after this time.[12]

11. According to statements made by Ms W, Child W was taken to either the Medicentre or Emergency Department of Frankston Hospital on numerous occasions due to constipation:

> "…*Lots of time I have taken her to the Frankston Hospital because of constipation. One time I went to the Medi Centre, but the other times it was the emergency part. The doctors would feel her belly and they would say there was still more poo in there. Three or four times they put something in her bottom to make her go to the toilet or lubricate the areas. I don't know. Other times they would tell me to give her laxative so I would go to the chemist and buy chocolate which was a laxative*."[13]

12. A review of Child W's medical records provides no evidence to support these claims.

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[6] Statement of Dr George Maragoudakis, pge 152.
[7] *Ibid.*
[8] Statement of Ms W, pge 28.
[9] Statement of Ms W, pge 28.
[10] Statement of Dr George Maragoudakis, pge 152.
[11] *Ibid.*
[12] *Ibid.*
[13] *Ibid.*

13. On 15 December 2010, Child W who had been living with her grandparents for some time, moved to a residence in Frankston North.[14] Once she was living at that house, Child W soon became friends with another child who lived close by, and would always play with her after school and on the weekends.[15]

14. In 2011, Ms W noticed that Child W's stomach was getting bigger, was rock hard and that it looked like she was pregnant.[16] Ms W thought that this was due to the amount of junk food Child W was eating and a lack of exercise.[17] Child W began complaining to Ms W that she had pains down the bottom of her stomach.

15. Ms W did not discuss Child W's stomach pains with the grandmother, and as a result, neither Ms W nor the grandmother sought medical treatment for Child W.[18]

16. In Term 4 of 2011, Child W's soiling problem appeared to be getting worse[19] as she was soiling herself almost every day at school. At home, Child W would soil her pants instead of going to the toilet and then change her clothes. The grandmother stated that Child W changed her underwear about four times a day due to soiling.[20]

17. On Saturday 24 December 2011, Child W spent Christmas Eve with her grandmother and grandfather along with other relatives at their home in Frankston North.[21] According to witness statements made by the grandmother and others, Child W seemed her usual self and was excited about Christmas. Child W ate some pork and cheese from a salad that her grandmother had prepared, and drank a can of Coke.[22] She then played outside with her friend until 9:00pm that night.[23] At about 10:00pm, Child W went to bed, and slept in her grandparents' bedroom.[24] Although Child W had her own bedroom, she rarely slept in it, as she was afraid of the dark and did not like sleeping in a room by herself.[25]

[14] Statement of grandmother, pge 35.
[15] Statement of Mr W, pge 73.
[16] Statement of Ms W, pge 29.
[17] *Ibid*.
[18] *Ibid* at pge 30.
[19] Statement of Lyn Bonner, pge 160.
[20] Statement of grandmother, pge 44.
[21] *Ibid* at pge 46.
[22] *Ibid*.
[23] *Ibid* at pge 47.
[24] *Ibid*.
[25] Statement of grandfather, pge 60.

18. Child W woke up a few times during the night and asked if Santa had been. She was told that he had not and to go back to sleep. The last time that Child W did this was at approximately 4:30am, on Sunday 25 December 2011.[26]

THE PURPOSE OF A CORONIAL INVESTIGATION

19. Child W's death was determined to be a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was it one that '*appeared*' to be unexpected.[27] I also refer to my comments regarding why this death is considered to be a 'reportable death' contained under the heading 'Comments pursuant to section 67(3) of the *Coroners Act 2008*' below.

20. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[28] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

21. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[29] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

22. The term 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

23. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

24. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

[26] Statement of grandmother, pge 47.
[27] Section 4 *Coroners Act 2008.*
[28] Section 89(4) *Coroners Act 2008.*
[29] *Keown v Khan* (1999) 1 VR 69.

25. Coroners are also empowered:

(a) to report to the Attorney-General on a death;

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

26. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[30] 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 that they caused or contributed to the death.

27. In writing this Finding, I have conducted a thorough forensic examination of the evidence including reading all of the witness statements in the coronial brief and reviewing relevant medical records.

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

Identity of the Deceased, pursuant to section 67(1)(a) of the *Coroners Act 2008*

28. On 25 December 2011, Child W was visually identified by Ms W, to be her daughter, Child W, born 2 June 2001.

29. Identity is not disputed and required no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the *Coroners Act 2008*

30. On 30 December 2011, Dr Yeliena Baber (**Dr Baber**), a Forensic Pathologist, practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Child W's body.

31. Dr Baber provided a written report, dated 16 April 2012, which concluded that a reasonable cause of death was '*Ischaemic Large Bowel and Large Bowel Obstruction secondary to Chronic Constipation*'.

[30] (1938) 60 CLR 336.

32. Dr Baber's report contains the following important comments:

> "*At autopsy, on external examination, she [Child W] was a well nourished child with a distended abdomen. Evidence of recent medical intervention was present. There was no sign of injury. On internal examination, the most striking finding was a grossly dilated rectum with impacted faeces completely filling the pelvic bowl and obstructing the colon. Proximal to this, there were liquid faeces throughout the colon, which was grossly distended. On opening the colon, the sigmoid and descending colon were ischaemic. Patchy ischemia was present in the transverse and ascending colon. No other significant natural disease was identified.*
>
> *Histology of the bowel showed fibromuscular hypertrophy and ischemia of the mucosa. Ganglion cells were present throughout. The thymus showed post inflammatory changes. No other significant natural disease was identified.*
>
> *Neuropathology showed no specific neuropathological abnormality.*
>
> *Toxicology was negative and the C-reactive protein (a marker or infection or inflammation) was normal. Vitreous electrolytes reflected post mortem changes only.*
>
> *In my opinion, death is due to bowel ischemia which has resulted directly from faecal impaction and dilation of the large bowel. Histology of the bowel has not been diagnostic, however, it has been possible to exclude Hirchsprungs's disease and the most likely cause of the chronic constipation is an undiagnosed motility disorder.*
>
> *If specific comment is required with respect to clinical management in this case, it should be sought from a paediatrician."*

33. I accept Dr Baber's conclusion as to Child W's cause of death and her comments contained in her report.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the *Coroners Act 2008*

34. At approximately 6:30am on 25 December 2011, Child W and the rest of the family woke up and gathered to open their Christmas presents.[31] When Child W awoke, she had become gravely ill and told her grandmother and the rest of the family, that she felt sick and had pains in the stomach.[32] Child W was no longer excited about Christmas, and reported that she felt too sick to open any of her presents. [33] Child W laid down in her bedroom (which was an unusual occurrence since she would usually lie on the couch when feeling unwell) while the rest of the family opened presents.[34]

[31] Statement of Mr W, pge 74.
[32] *Ibid.*
[33] *Ibid.*
[34] *Ibid.*

35. Her grandmother went to check on Child W and gave her a drink of water, which caused Child W to dry retch and vomit small amounts of water.[35] Shortly afterwards Child W went to the toilet, where she then had diarrhoea.

36. Her grandmother felt Child W's forehead to see if she had a temperature and noticed that she felt cold.[36] Her grandmother told Child W that she was probably just hungry and that they would buy her some McDonald's and get her something to drink.[37] The family then went to visit a cemetery where some family members were buried, to place flowers on the graves.

37. On the way back home, the family drove to McDonald's in Frankston North, where they went through the drive-thru and ordered some food for themselves and for Child W. Whilst they were waiting for their order, Child W opened up the car door and vomited water onto the ground.[38] Her grandmother then offered Child W a bacon and egg McMuffin but she refused it, saying that she was too sick and did not want anything.[39] Everyone thought that this was very unusual for Child W as McDonald's, one of her favourite foods, was consumed by her nearly every day.[40]

38. Upon returning home at about 10:30am, Ms W was waiting for the family.[41] Child W went and sat on the couch and paid very little attention to her presents.[42] At about 11:00am, Child W, her grandmother and the rest of her family went to Ms W's house for Christmas lunch.[43]

39. Upon arrival, Child W laid down on the couch in the lounge room and immediately vomited on the floor.[44] She then proceeded to go to the toilet where she had further episode of diarrhoea. After this, Child W went to the toilet "*every five minutes*."[45] She was noticed to be pale, weak and struggling to walk.[46]

40. Child W did not eat anything whilst she was at her mother's house, but according to Ms W, Child W drank numerous glasses of water, which she vomited up straight away.[47]

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[35] *Ibid*.
[36] *Ibid* at pge 49.
[37] *Ibid*.
[38] *Ibid*.
[39] Statement of grandfather, pge 62.
[40] *Ibid*.
[41] *Ibid*.
[42] Statement of Mr W, pge 75.
[43] Statement of Ms W, pge 31.
[44] *Ibid*.
[45] Statement of grandmother, pge 50.
[46] Statement of grandfather, pge 63.
[47] Statement of Ms W, pge 31.

41. The grandparents thought Child W was sick with gastroenteritis, as she had had '*gastro*' before and was presenting with identical symptoms.

42. During the early afternoon, her grandmother and the rest of her family left Ms W's house to have Christmas dinner with her son and his family in Pakenham.[48] Child W was supposed to go with them, but was too sick and had become exhausted.[49] During the afternoon Child W complained of stomach pains and a sore back and frequently went to the toilet with vomiting and diarrhoea. At approximately 6:00pm, Ms W ran a bath for Child W because she had soiled herself.[50]

43. Ms W reports that while Child W was in the bath, her skin turned blue and she told Ms W that she could not see.

44. Ms W called for her partner, Mr H to assist her and then called 000.[51] Child W was no longer speaking and her eyes had rolled back into her head.[52]

45. Frankston MICA unit received the call to attend at 6:49pm and arrived at 6:50pm.[53] Upon their arrival, they observed Child W slumped in Mr H's arms. At this time, she was in full cardiac arrest. [54]

46. The MICA unit commenced cardiopulmonary resuscitation (**CPR**). A Karingal Ambulance unit arrived a short time later and assisted the MICA unit at the scene with CPR, administering intravenous adrenaline and normal saline, and endotracheal intubation.[55] Child W was recorded as achieving cardiac output at 7:33pm.

47. Once Child W was stabilised, she was transported to Frankston Hospital at 7:51pm, and arrived at the Emergency Department at 7:58pm, where she re-arrested. Hospital staff continued to administer CPR for an hour; however, Child W was unable to be revived.[56] Child W was pronounced deceased at 8:58pm.

[48] Statement of grandmother, pge 51.
[49] Statement of Ms W, pge 31.
[50] *Ibid* at pge 32.
[51] *Ibid* at pge 33.
[52] *Ibid*.
[53] Statement of Sally Raisbeck, pge 133.
[54] Statement of John Zorzi, pge 136.
[55] *Ibid* at pge 137.
[56] *Ibid*.

EXPERT OPINION

48. Dr Elizabeth McLeod, Paediatric surgeon, was asked to comment on Child W's case and, for that purpose, provided a report dated 26 August 2015. Her discussion of the matter indicates that in her view:

> "*It is likely that there were significant social issues for Child W in regards to shared care between her mother and grandparents…who had very different philosophies on diet and what would be considered normal bowel function. Ms W indicates that she did realize for example that Child W's diet was extremely poor, but…that she felt powerless to change this given the role of her mother in Child W's care*."

49. As to the medical management of Child W during her life, Dr McLeod stated:

> "*Most children with idiopathic constipation do not have extensive investigations and are managed by their families and GP quite adequately. Only a small minority of children require the assistance of specialised clinics that would be offered at large tertiary centres*."

50. In Dr McLeod's opinion:

> "*the delay in seeking assistance was due to the family's poor understanding of health in general rather than it being an act of commission."*

51. Dr Susan Gibb, consultant paediatrician, provided an expert opinion, dated 7 May 2016, concerning the recommended management for constipation associated with faecal incontinence in children. This document is marked **Attachment A** to this finding. Dr Gibb also provided her professional opinion on the familial and medical management of Child W during her life time.

52. As to the latter, Dr Gibb notes that at the 2010 consultation with Dr Maragoudakis, there was dietary advice and laxatives provided as a second line treatment, but that a regular toileting program was not mentioned. Dr Gibb does note Dr Maragoudakis' request for follow up of Child W, and that this does not seem to have occurred. Given his infrequent contact with Child W and her family, and the fact that despite requests from Dr Maragoudakis, the family did not bring Child W back for follow up appointments, I am not critical of Dr Maragoudakis' failure to provide what Dr Gibbs considers to be the "*gold standard*" treatment of for chronic constipation. However, I do note that education of parents of children like Child W who have chronic constipation, especially concerning the need for a regular toileting program, is an essential component of proper medical management of those children.

53. Those responsible for Child W's care, while she was at school, formed the belief that her soiling was "*attention seeking*" behaviour. It is clear that it would be desirable for those charged with the care of young children who, like Child W, may be suffering from the effects of chronic constipation, to be sufficiently well educated about the causes and management of the problem, to be able actively to encourage parents to seek professional assistance, rather than to steer parents or guardians down a counterproductive disciplinary path, in the belief that the child is engaged in a deliberate action when soiling themselves.

54. Sadly, Dr Gibbs' notes that:

> "*if medical advice had been sought in the months prior to her death there would have been an opportunity to treat Child W's severe constipation and faecal incontinence with a multimodal therapy program. This treatment, even if only partially successful, would have reduced the severity of the faecal impaction and the likelihood of developing the extremely rare complication of bowel ischemia*." [57]

55. She continues:

> "*In addition on the day of her death it appears to me that her family failed to appreciate the severity of her illness in a timely manner. She was unwell all day with worsening abdominal pain, profuse vomiting, diarrhoea and multiple incontinence episodes and deteriorating consciousness. Whilst her condition was already extremely serious, it is my opinion that presentation to a hospital prior to her cardiorespiratory arrest with an acute abdomen would have potentially been a recoverable condition*."[58]

COMMENTS PURSUANT TO SECTION 67(3) OF THE *CORONERS ACT 2008*

56. The death of a child is a devastating event for their family, loved ones and those persons involved in their care. This is particularly difficult when the child dies in what appears to be 'unexpected' circumstances.

57. Child W's death was reported to the Court, by the Hospital, on the reasonable belief that it was a 'reportable death'. A review of the e-Medical Deposition Form (**E-Med Dep**), does not clearly articulate the criteria contained in section 4 of the Act, relied upon by the Hospital, to notify Child W's death to the Court. The E-Med Dep provides a possible cause of death to be '*bowel perforation*'. Given the circumstances of Child W's death, I am satisfied that the most relevant 'reportable death'[59] criteria applicable is that the death was that it was '*unexpected*'. However, that is not without complications.

[57] I note that Dr McLeod expresses a similar opinion in her supplementary report dated 19 October 2015.
[58] *Ibid*.
[59] Section 4(2) of the *Coroners Act 2008*

58. Having conducted an extensive coronial investigation into the circumstances of Child W's death, I am satisfied that her death would not have been unexpected had she received the appropriate and necessary medical treatment to treat her encopresis prior to her attending at the Hospital on the day of her death.

59. While I am satisfied that Child W's medical treatment at the Frankston Hospital was appropriate and necessary and that the medical procedures conducted upon her did not cause or contribute to her death, I am also satisfied, on the available evidence, that there were missed opportunities prior to her attending at the Hospital to get her the necessary and appropriate treatment that could have prevented her death.

60. I accept that Child W's family loved her dearly. I also accept that those persons responsible for her care outside the family unit, such as her teachers and doctors, did what they thought was best for Child W at the time. However, it is clear that Child W did not receive the necessary and appropriate responses to address her encopresis.

61. It is not my role to apportion blame, and nor do I not seek to do so. However, there are important lessons to be learned from the responses by all persons involved in Child W's life in relation to her condition of encopresis. It is clear from my investigation that there is a lack of understanding of how to manage children who suffer from encopresis. It is for these reasons that I make the recommendation below, as I consider these entities are best placed to implement appropriate training for responding to children who exhibit symptoms of encopresis.

62. I am satisfied, having considered all of the available evidence, that no further investigation is required.

RECOMMENDATION

63. Pursuant to section 72(2) of the Act, I make the following recommendation connected with Child W's death:

    (a) that Catholic Education Melbourne and the Department of Education and Training each review its training policies and procedures for their respective staff, who have contact with children, to ensure that it is consistent with the Royal Children's Hospital document titled 'Recommended Management for Constipation Associaed with Faecal Incontenience in Children' (see Attachment A).

FINDINGS AND CONCLUSION

64. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Child W, born 2 June 2001;

(b) that Child W died on 25 December 2011, at Peninsula Health (Frankston Hospital), 2 Hastings Rd, Frankston, Victoria, from ischaemic large bowel, caused by a large bowel obstruction secondary to chronic constipation; and

(c) that the death occurred in the circumstances set out above.

65. I convey my sincere condolences to Child W's family and friends for her death.

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

(a) Ms W, senior next of kin.

(b) Detective Senior Constable Christopher Nieuwesteeg, Coroner's Investigator.

(c) Dr George Maragoudakis.

(d) Dr Elizabeth McLeod (MD FRACS (Gen) FRACS (Paed).

(e) Dr Susan Gibb (MBBS, FRACP), Consultant Paediatrician, Royal Chilren's Hospital.

(f) Ms Marini Mann, Gilchrist Connell Lawyers, solicitor for the school.

(g) Professor Jeremy Oats, Chair, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity.

67. I direct that a copy of this finding be provided to the following persons for response to the Recommendation:

(a) Ms Gill Callister, the Secretary of the Department Education and Training.

(b) Mr Stephen Elder, Executive Director, Catholic Education Melbourne, Post Office Box 3, East Melbourne, 8002.

68. I directed that a redacted copy of this finding be providing the following persons for inclusion in their training policies and procedures:

(a) Ms Ms W Burns, Legal Counsel, Peninsula Health (Frankston Hospital).

(b) the Royal Australian College of General Practitioners.

(c) the Australian College of Rural and Remote Medicine.

69. Pursuant to section 73(1) of the Act, I order that a redacted copy of this Finding be published on the internet.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 6 April 2017