IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2006 / 4223

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: MARCUS MICHAEL CHRISTOPHER CHARLES

Delivered On:	17 March 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	23 May 2011 24 May 2011 25 May 2011
Findings of:	PETER WHITE, CORONER
Representation:	Ms Michelle Charles, on behalf of the family of Marcus Charles. Mr M Wilson with Ms D Foy appeared on behalf of Ambulance Victoria Ms M Wilson appeared on behalf of Department of Human Services
Police Coronial Support Unit	Leading Senior Constable King Taylor

I, PETER WHITE, Coroner having investigated the death of MARCUS MICHAEL CHRISTOPHER CHARLES

AND having held an inquest in relation to this death on 23, 24 and 25 May 2011

at Melbourne

find that the identity of the deceased was MARCUS MICHAEL CHRISTOPHER CHARLES

born on 21 July 2006, aged 3 months

and the death occurred on 5 November 2006

at Westgarth Street, Northcote 3070

from:

1 (a) COMPLICATIONS OF SMALL BOWEL OBSTRUCTION DUE TO POST OPERATIVE ADHESIONS

in the following circumstances:

Medical Background

1. Baby Marcus Charles (hereon referred to as Marcus), was born prematurely on 21 July 2006 at the Northern Hospital to Michelle Charles and Patrick Hall. Marcus was Michelle Charles ninth child. It is relevant to record that Ms Charles appeared to the Court to be of gentle disposition, and I further record that she was of aboriginal descent.

2. Marcus had three older full brothers and four living half siblings. In 1989, Michelle Charles had lost an infant and Marcus's death was therefore a reviewable death under the Coroners Act. The family had a significant level of contact with child protection workers, who were assisting the family, both before and after Marcus birth. I note here that Marcus parents were both viewed by those authorities to be loving and responsible parents..

3. Marcus was initially diagnosed with Oesophageal Atresia, Trachea-oesophageal Fistula and Duodenal Atresia at birth. These were medical conditions associated with his oesophagus and bowel, requiring him to be transported from the Northern Hospital soon after his birth, to the Royal Children's Hospital (RCH) for surgery.

4. He was transferred to the RCH July 22 2006 where he was diagnosed with the two conditions described above. The first, oesophageal atresia occurs when a section of the oesophagus is missing and the oesophagus is incorrectly connected to the trachea. As a result, Marcus underwent surgery for the repair of his oesophageal atresia and ligation of a trachea-oesophageal fistula.

5. In addition, Marcus suffered from a duodenal atresia as a section of his bowel had not correctly formed. There were no external signs associated with this condition and it was not identified until shortly after his birth. A duodeno-duodenostomy was then also performed. Marcus was extubated three days later.

6. It was explained that the surgery then undertaken was successful with the surgeon disconnecting the lower part of his oesophagus and reconnecting it to the upper oesophagus. Marcus' bowel was then closed in order to make one continuous bowel. He was described at that time as having an excellent prognosis.

7. Marcus was transferred back to the Northern Hospital on 11 August 2006. On 17 August 2006, he was discharged home into the care of his parents. At this time Marcus prognosis was good, although he needed to attend outpatient appointments with specialists, for ongoing monitoring of his progress.

8. On 24 August 2006, Marcus was reviewed by Dr Joe Crameri, Paediatric Surgeon, who originally saw him at the Royal Children's Hospital. Dr Crameri wrote to Dr Anastasia Pellicano to report on that meeting. This letter recorded that Marcus was acting 'like a normal baby and feeding well without any obvious reflux or difficulty swallowing'[1]. Dr Crameri notes that he warned Marcus's mother that it might be necessary for him to undergo some oesophageal dilation but that he would only plan to do this once Marcus developed symptoms of obstruction.[2]

9. Marcus lived with his mother, father and three brothers at the William T Onus Hostel in Northcote.

10. The medical records from the Royal Children's Hospital show that Dr Pellicano, a neo-natalist, reviewed Marcus on 7 September 2006 and again on 30 October 2006 and reported Marcus to be thriving a home. There were nil concerns at that time.

3 - 4 November 2006

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[1] Letter from Dr Joe Crameri to Dr Anastasia Pellicano dated 28 August 2006, exhibit 1(b)

[2] Ibid. I note here that Ms Charles also testified that she was advised (by Dr Crameri) to keep a close watch for changes in behaviour, which included vomiting. See transcript at page 32 and exhibit 1(b).

Michelle Charles[3]

11. Michelle Charles reported that in the three days prior to 5 November 2006, she observed that Marcus was unwell, off his bottles and refusing to drink. The day before Ms Charles called the first ambulance (4 November), Marcus began to vomit.[4] Ms Charles reported that the vomit had a bad smell and looked like diarrhoea.[5]

12. On 4 November 2006, at approximately 9.13 am, Ms Charles through the Hostel, assistant manager, called Emergency Services[6] as Marcus had been ill during the night. An Ambulance was dispatched at 9.14 am and arrived at the scene at 9.21 am.[7] The details printed on the ambulance pager were recorded as 'SOB, sweaty or changing colour'. Ambulance Members Mr Byron Chilcott and Mr Bruce Sutherland attended at the scene. Mr Chilcott was a student paramedic, and took the lead on this occasion.

13. Ms Charles evidence in relation to the 4 November 2006 ambulance attendance is as follows:

    a. When the ambulance arrived, she spoke to one of the members and told them that Marcus had had an operation the day after he was born because 'the tube that went into his tummy was connected to his lung'[8]. It is unclear whether she mentioned that Marcus had had an operation on his bowel too. She also remembered showing them the bottles of medication that Marcus took[9] including a bottle of Zantac.[10]

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[3] Statement of Michelle Charles, Exhibit 1, p1.

[4] Ibid.

[5] Ibid – contentious evidence whether this was the case. (Notes taken by Doctor Azzopardi after Marcus' death when Marcus was taken to the Royal Children's Hospital indicate that on Saturday 4 November, the vomit was white/yellow in colour.[5] These notes also indicate that on the morning of Sunday 5 November, Marcus continued to vomit but it was green, brown and feculent.[5] I note that there is discrepant evidence about the colour of Marcus' vomit on Saturday 4 November, particularly in relation to what information was conveyed to the attending ambulance members, which I will deal with below)

[6] VACSIS electronic Patient Care Report from 4 November 2006 p1.

[7] I note that the Patient Care Report indicated that the ambulance members were at the scene at 9.21 and at the patient at 9.35am. Mr Chilcott's evidence is that the 9.35am time was incorrect and that it would not have taken 14 minutes from arriving at the scene to then get to the patient. I accept this evidence.

[8] Transcript page 15

[9] Transcript page 44

[10] Ibid

b. She stated that Marcus had been vomiting but he was relaxed and more calm, when the ambulance members were there.[11] Marcus did not vomit while they were there[12] and he was not crying or irritable.[13] She could not recall if she told Mr Chilcott about the colour of the vomit or its odour[14] however later in evidence she said that she did tell Mr Chilcott that the vomit smelt like diarrhoea.[15] Ms Charles stated that she showed Mr Chilcott a towel that she had used to clean up Marcus' vomit[16] and that she had kept the towels to show the doctors how much Marcus had been sick.[17] Ms Charles stated that on 4 November the vomit was brown in colour and smelly.[18]

c. Ms Charles pointed out the surgical scaring.[19] When put to her if she recalled that Mr Chilcott asked for Marcus' baby book, she could not remember if that was the case.[20]

d. Mr Chilcott examined Marcus and according to Ms Charles, after this examination she felt that maybe she had overreacted about how sick he had been.[21] Ms Charles' recollection was that the ambulance members told her that Marcus was fine and she did not recall anyone saying anything about going to hospital.[22] She said that when they first arrived she told them she wanted to go to the Children's Hospital.[23] Ms Charles got the impressions from the ambulance officers that Marcus was not sick. She recalled being told that if Marcus vomited again she could call the ambulance back.[24]

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[11] Transcript page 18

[12] Transcript page 45

[13] Ibid

[14] Transcript page 22

[15] Transcript page 24

[16] Transcript page 40

[17] Ibid

[18] Transcript page 72

[19] Transcript page 9

[20] Transcript page 49

[21] Transcript page 19

[22] Transcript page 51

[23] Transcript page 57

[24] Transcript page 16

Mr Byron Chilcott [25]

14. Mr Chilcott's evidence about the 4 November, attendance was as follows:

a. On arrival at the scene he spoke to Ms Charles. She said that Marcus had vomited twice overnight and she was concerned.[26] He attempted to obtain a medical history and she told him that Marcus had had an operation and she produced his yellow vaccination book.[27] He asked for documentation from the hospital about the surgery and nothing was produced.[28] He stated that it took him a while to obtain a history as Ms Charles was a little unclear about his history.[29] The history that he did elicit was that Marcus had an operation of his oesophagus, but no further detail about that operation,[30] and that Marcus had an enlarged liver.[31]

b. Mr Chilcott did an assessment of Marcus from top to bottom.[32] The full examination involved a primary survey and a secondary survey.[33] He picked Marcus up and listened to his chest from the back,[34] he checked his pulse, examined his body for haemorrhages, bleeding and rashes.[35] He also palpitated Marcus' abdomen[36] but did not remember seeing the scar on Marcus' abdomen.

c. Mr Chilcott noted that Marcus was responsive and not lethargic and that he was acting age appropriate.[37] His statement indicated that he ascertained that both vomits occurred directly after feeding, that he had not vomited for a while and he now

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[25] See statement of Byron Chilcott dated 31 December 2008, Exhibit 2 p1.

[26] Transcript page 90

[27] Transcript page 91

[28] Ibid

[29] Transcript page 94

[30] Transcript page 95

[31] Ibid

[32] Transcript page 94

[33] Transcript page 108 Mr Chilcott indicated that the secondary survey is a top to bottom survey, that is, going from head to toe to look for any abnormalities. Transcript page 108

[34] Transcript page 97

[35] Ibid

[36] Transcript page 100

[37] Statement of Byron Chilcott, Exhibit 2

appeared a lot better.[38] His observations were recorded electronically on the Patient Care Report, (PCR).

d. In relation to the PCR, Mr Chilcott acknowledged that they were badly written in this case and alleged that this was due to the electronic form of PCRs being new at the time.[39] At this point in time, he had had about four hours worth of training on the electronic PCR system.[40]

e. He gave evidence that while at the scene Ms Charles did not say to him that she wanted Marcus to go to hospital.[41] He stated that her desire for Marcus to go to the Royal Children's Hospital, was never mentioned.[42] He was of the impression that she wanted him to assess Marcus and that when examined his presentation was in the normal parameters.[43] Again, the patient care report notes that patient transport was not required, however Mr Chilcott was unfamiliar with the electronic system.

f. After the examination, Mr Chilcott stated that he recommended that Marcus go to the Austin Hospital. He further stated that he made this recommendation because:

> *Because we were given a history. The baby was - Marcus was only - Marcus was only several months old. He was very young. He had some sort of an operation which I was still unclear of, that was enough for me to suggest to Ms Charles, look, and this is what I've said to her, "At this point in time, we've done a full assessment, I can't find anything wrong with your child at this point. But I suggest that we go down to the Austin because your baby has some sort of a history which sounds significant." But that's all - that's all she'd give me, so that's all I could go on. It's called the pay off principle.*[44]

g. His evidence in relation to Ms Charles' reaction to the suggestion that they go to him was:

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[38] Ibid

[39] Transcript page 103

[40] Transcript page 111

[41] Ibid

[42] Transcript page 112

[43] Ibid

[44] Transcript page 113

She was, sort of, like, umming and ahhing type of thing. And I just said, "Look, I can't make you go, but I strongly suggest, with the history, we take your child down." That's when she said, "No," and then I said, "Well, if you elect not to go I recommend that you go and see your local medical officer, or your doctor."

And that was - that was about it.[45]

h. His further evidence was that he then told Ms Charles that they should see how Marcus was overnight and if she had any concerns she could call them back.[46] I note that there was some discussion about whether the recommendation that Marcus go to hospital was an offer, suggestion or recommendation however Mr Chilcott's evidence was that he used the word recommend at the scene.[47]

i. He also strongly disagreed with Ms Charles' statement that she was left with the impression that he did not want to take Marcus to hospital.[48] The determining factor in giving his advice that Marcus should go to hospital was that he had had some kind of operation on his oesophagus.[49]

j. He further stated that this conversation was not recorded in the PCR due to his inexperience with the new system.[50]

k. He denied that he told Ms Charles that Marcus was probably vomiting to purge the medications from the operation from his system.[51] He also denied being shown a towel used to clean up Marcus' vomit[52] and told anything about the colour of the vomit.[53]

l. See also Mr Chilcott's evidence at transcript page 97- 102, where he first denied noticing the scar to the abdomen, and then denied knowing whether if such a scar did

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[45] Transcript page 114

[46] Transcript page 117

[47] Transcript page 136

[48] Transcript page 136

[49] Transcript page 160

[50] Transcript page 115

[51] Transcript page 117

[52] Transcript page 166

[53] Ibid

exist, it was indicative of an oesophageal surgery or other. His further testimony was that he did not consider it relevant.

Bryce Sutherland

15. Mr Sutherland attended with Mr Chilcott on 4 November 2006 and observed his assessment of Marcus. Mr Sutherland was the non-attending paramedic and his role was to assist Mr Chilcott by collecting equipment.[54] He gave evidence that they were told that Marcus had an operation on his oesophagus but other than that, the information was not forthcoming.[55] He was unaware of Marcus' operation on his bowel until two weeks before the inquest.[56]

16. Mr Sutherland could not remember a towel being presented to them by Ms Charles at any time during their attendance on Marcus.[57] He stated they were told vomits had taken place after a feed which he did not think was unusual, and that it was never described to them as being dark in colour.[58] From his observation of the situation, he saw what appeared to be a healthy child.[59]

17. He confirmed that Mr Chilcott offered to take Marcus to hospital[60]and that the offer was more of a recommendation.[61] His evidence was that even though Marcus was presenting well, as a matter of course they offer transport to patients, and if they really wish to be transported, he would not talk them out of it.[62] He got the impression that Ms Charles was happy to not go to hospital and to see the local doctor instead.[63] Mr Sutherland's evidence was that the decision not to transport, was made in consultation with Ms Charles[64] and he

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[54] Transcript page 180

[55] Ibid

[56] Transcript page 202

[57] Transcript page 181

[58] Transcript page 181

[59] Ibid

[60] Transcript page 184

[61] Transcript page 205

[62] Transcript page184

[63] Transcript page 187

[64] Transcript page 201

did not recall Ms Charles saying she wanted to take Marcus to the Royal Children's Hospital.[65]

Events following the departure of Ambulance Officers and Clinical Case Review

18. For the rest of the day Marcus remained well.[66]

19. On the morning of 5 November Marcus was unwell and Ms Charles and Mr Hall tried to take him to the doctor but it was closed.[67] They went to the pharmacy and the pharmacist told them to take Marcus to the hospital.[68] They went home to pick up Marcus' stuff to go to the hospital[69] but decided to call an ambulance because Marcus looked worse.[70] The Ambulance attended, however Marcus' condition had deteriorated and he was unable to be resuscitated.

20. Dr Franz Babel from the Royal Children's Hospital referred this case to the Metropolitan Ambulance Service for a review.[71] A clinical case review was conducted by Mr Colin Jones. Mr Jones prepared a Clinical Case Review Report[72] (CCRR) and attended court to give evidence and I granted leave for him to give opinion evidence.[73] The CCRR is Mr Jones' record of his investigation into what occurred and was prepared for the purposes of teaching, training and quality control.[74] The Report is prepared on the basis of administrative documentation such as the Patient Care Report, conversations with the attending members and discussions with the complainant.[75] The report was then considered

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[65] Transcript page 206-7

[66] Transcript page 60

[67] Transcript page 62

[68] Transcript page 76

[69] Ibid

[70] Transcript page 78

[71] Mr Jones gave evidence that this case would have been reviewed regardless of Dr Babel's report as there is an automatic trigger for cases where an ambulance attends and does not transport a patient and an ambulance has to re-attend in a set period of time. Transcript page 223.

[72] Clinical Case Review Report, Exhibit 4

[73] Transcript page 219

[74] Ibid

[75] Transcript page 225

by an expert committee within Ambulance Victoria that sits as a sub-committee to the Medical Advisory Committee.[76]

21. The CCRR noted the following issues[77]:

a. Clinical Knowledge: The crew were not aware of the potential seriousness of this child's vomiting given the underlying medical condition.

b. Clinical Problem Solving: There was a gap evident in linking the history of oesophageal repair to the presenting complaint of vomiting.

c. Documentation: The PCR is inadequate. There is no mention made of any discussion with the mother about the various options, nor any offer of transport, nor the final decision of the mother to attend the LMO.

22. Ultimately Mr Jones' recommended that a level 3 clinical variation (clinical judgement) was found to have occurred.[78] The Level 3 and Level 4 Clinical Variations Committee[79] reviewed the report. The minutes of the meeting were provided to the Court and indicate that Mr Jones' recommendation was supported.[80] The committee also considered whether this case fitted the Sentinel Event Criteria, that is whether the ambulance officer's actions actually caused harm to someone.[81] The Committee decided that it did not fit the criteria because to their knowledge, the patient was followed up by a local medical officer post ambulance attendance and that there was doubt whether the ambulance service contributed to the outcome.[82] I note that this information was incorrect and Marcus did not see a doctor after the ambulance attended. Mr Jones' evidence was that the family was not contacted in the review process.[83]

23. I also note that this case was used as part of Ambulance Victoria's Continuing Education Program. Mr Jones also stated that inter-personal skills training is part of basic ambulance

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[76] Transcript page 220

[77] Clinical Case Review Report Exhibit 4 p2

[78] Ibid. Page 3 of the CCRR indicates that a level 3 variation is an action or inaction which potentially had significant adverse impact on the patient's condition. I note that since 2007, the levels have altered slightly.

[79] Now called the Sentinel Events Committee

[80] Exhibit 4A.

[81] Transcript page 236

[82] Transcript page 236, Exhibit 4A

[83] Transcript page 233. See also Findings and Conclusion from page 15 below.

officer training including general ethnic and cultural background training and dealing with people at all levels of the spectrum from very aggressive to very passive.[84]

Medical Findings post mortem

Professor Stephen Cordner

24. Professor Stephen Cordner of the Victorian Institute of Forensic Medicine performed an autopsy on 7 November 2006. Professor Cordner recorded the cause of death as complications of small bowel obstruction due to post operative adhesions. Professor Cordner attended Court to give evidence.

25. Professor Cordner's Autopsy Report[85] noted that:

> *There was obvious small bowel obstruction caused by a fibrous band entrapping a loop of small bowel and preventing the passage of bowel contents. This has caused the bowel to be blocked, a very serious situation. The entrapped loop of bowel was viable, that is blood supply to the bowel had not been compromised by the band in which it was trapped. In addition there was no peritonitis.*
>
> *Numerous samples for testing were taken at the autopsy. These showed that a particular virus, picornavirus, was present in the nasopharyngeal aspirate, that is the fluids at the back of the nose. And the right and left lungs. One particular type of picornavirus is known as enterovirus. As that name implies, that's a virus that causes illness in the - in the gut. It cannot be said as a firm conclusion that enterovirus was in fact present but in view of the history it is possible that the event started with an enterovirus bowel infection resulting in gastroenteritis. This in turn may have triggered some increased bowel motility, that is increased movement of the bowel which increases the likelihood of entrapment of the bowel by the fibrous band.*
>
> *The autopsy findings themselves alone cannot indicate or conclude when, during the course of Marcus Charles' final illness the obstruction occurred. It would have been present for some hours at least before death to result in the particular form of fluid that was present in his stomach.*

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[84] Transcript page 246

[85] Autopsy report, Exhibit 5, p6

26. In evidence, Professor Cordner stated that the lungs contained feculent material and it had started to cause infection in the lung. The infection looked relatively recent but he could not say when it had started.[86] He agreed that Marcus was always going to be susceptible to bowel obstructions given his medical history. It may be that without the picornavirus, that indicated possible gastroenteritis, the obstruction may not have occurred as the stomach would not have been as mobile, however there was always the risk that it would occur on a future occasion.[87]

27. Professor Cordner also noted that Marcus might have been slightly dehydrated but he was not severely or moderately severely dehydrated[88] and that 'there was nothing from my findings to indicate that this child would have had a degree of dehydration which somebody might have picked up'.[89]

28. When questioned about the colour of the vomit, and whether on the Saturday, if the vomit was a white colour, this would mean that the bowel obstruction was not in place, Professor Cordner stated that it may have been just starting but he couldn't say.[90] He did note that there was no interference with the blood supply in the bowel. In that situation it may be hard to differentiate between a blocked bowel and gastroenteritis.[91]

Expert opinion of Professor Tibballs

29. As part of my investigation, I requested an opinion from Professor James Tibballs, Physician in the Intensive Care Unit of the Royal Children's Hospital. Professor Tibballs provided me with a letter and attended Court to give evidence. I gave Professor Tibballs leave to give opinion evidence.[92] I also provided Ambulance Victoria with the opportunity to respond to Professor Tibballs. It became apparent during the inquest that Professor Tibballs had not been provided with all pages of the patient care report at time of writing his statement and the full document was handed to him in Court.

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[86] Transcript page 253

[87] Transcript page 256

[88] Transcript page258

[89] Ibid

[90] Transcript page 262

[91] Transcript page 263

[92] Transcript page 272

30. In Professor Tibballs' opinion, the ambulance officers did not adequately elicit Marcus' medical history and such a medical history was needed in order to determine if transportation to hospital was required.[93] After reading the full PCR, he remained critical of the history gained by the ambulance officers and stated that:

> *Other than that there's a history of an oesophagus operation and enlarged liver and is on Zantac syrup, but nothing else is particularly additional.*[94]

31. He further queried how the ambulance officers interpreted the information that of Marcus' oesophageal surgery and whether they interpreted that as an operation on the thorax rather than the abdomen. There was also no information about the bowel surgery.[95] In his opinion, more information in relation to the vomit should have been elicited.

32. When questioned whether he would have been overly worried if a baby presented to him and he was aware of the oesophageal operation and vomiting, Professor Tibballs stated that he would not be but he would not be content because he would not have a diagnosis.[96] He acknowledged that the ambulance officers would be relying almost entirely on what the parents conveyed to them and he would not expect them to ring the hospital to get more detail.[97] The underlining is mine. He also referred to the need to persevere to get other historical information and that he would not form an opinion,

> *'unless I obtained as much history as possible and examined the infant to assure myself that the vomiting was benign.'* [98]

33. Professor Tibballs when asked if it was unlikely that Marcus would remain well for the rest of the day if the vomits on the morning of 4 November were feculent, stated that:

> *[I]f faecal vomiting was present that means bowel obstruction. I wouldn't expect that situation to right itself, I would expect the infant to deteriorate during the day.*[99]

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[93] Statement of Professor Tibballs, Exhibit 6 p 2

[94] Transcript page 275

[95] Transcript page 276

[96] Transcript page 280

[97] Transcript pages 283– 284

[98] Transcript page 289

[99] Transcript page 293

Mr Kevin Masci

34. Mr Kevin Masci, Regional Manager of the Loddon Mallee Region for Ambulance Victoria provided a statement to the Court in response to Professor Tibballs' criticisms and also outlining protocols that exist in reference to the examination of children and whether to transport them to hospital.[100]

35. Mr Masci's statement indicated that the ambulance officers did elicit a medical history and it was noted on the PCR. He also outlined that Ambulance Victoria has a set of Clinical Practice Guidelines in relation to children.[101] The decision whether to transport a child to hospital is made after taking into account various factors including, the child's complaint, symptoms, medical history, physiological parameters, location, age, hospital and family wishes.[102] In oral evidence, Mr Masci stated that all ambulance officers are expected to have a very good knowledge of the guidelines.[103]

36. Mr Masci stated that calling the hospital to get a more detailed history of the patient is not practical.[104] He also described the pay-off principle that is applied in situations where a patient presents well but there is a reason the ambulance has been called and they are not sure what is wrong. In these situations, the pay off principle is applied and the person is taken to hospital.[105]

Findings

I have now reviewed the evidence of Ms Charles and that of the ambulance officers, and the expert witness Professor Tibballs, and the evidence of Mr Masci, together with relevant medical records and counsel's written submission.

Concerning the evidence about the handing over of the soiled from vomit towel, I find that I am not satisfied that Ms Charles did in fact provide same to the ambulance officers on the 4th. In this regard the evidence of the officers, and the inconsistent statement to the RCH by Ms Charles on this issue, (and my belief that the officers would have acted more decisively if they had been shown such a towel), all persuade me that I should not be satisfied as to this allegation.

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[100] Statement of Kevin Masci, Exhibit 7

[101] Ibid p5

[102] Ibid p6

[103] Transcript page 302

[104] Transcript page 303

[105] Transcript page 311

I further find that the taking of a history by Mr Chilcott was unsatisfactory.

In the circumstances, I consider that either Mr Chilcott or Mr Sutherland should have asked more questions of either Ms Charles or Mr Hall, who on the evidence was present and not questioned at all. Had that course not provided more certain information both officers should then have apprehended that the results so far reached, could not be relied upon as part of a basis for a reasonably informed opinion as to how to proceed safely.

Again, the evidence does not suggest that the officers inquired as to the availability of a Discharge Note concerning such surgery (earlier provided by RCH, with other relevant written and oral advice), which inquiry I find, should also have been made.

I also find that having regard to the fact that there was a history from the mother unresolved, which was suggestive of a congenital deficiency of uncertain nature, (operated) on an infant of 3 months, and unexplained vomiting, that it was imperative that both officers' proceed with firmness. [106]

Such an approach should have resulted in a strong recommendation to the parents in favour of the transporting of the child and his mother to hospital for further investigation and review. Despite evidence to the contrary, I find that Mr Chilcott's conversation with Ms Charles on this issue, was at best equivocal and that the 'Pay Off principal' so called, was simply not applied.

I further find that had a firm recommendation suggesting transfer to hospital been made, that this advice would have been followed by Ms Charles whom I am satisfied was an experienced and concerned mother.[107]

It is relevant context that she had called an ambulance in respect of her 3-month-old child operated, who had a complex medical history, this following several incidents of vomiting, about which possibility she had earlier been informed.[108] I find then that she undertook this course of action with an expectation of having her son transported back to the RCH, for a medical review, in her company.[109]

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[106] See Professor Cordner's report at exhibit 5 page 2, where he refers to the 8cm surgical scar extending across the abdomen above the umbilicus. See also Mr Chilcott's evidence from transcript page 97, where he denied noticing the scar to the abdomen, and then knowing whether if such a scar did exist, it was indicative of an oesophageal surgery or other.

[107] I also note that Ms Charles appeared to the Court as someone who was reticent in disposition and perhaps somewhat vulnerable to suggestion. I find that she accepted the examination findings of Mr Chilcott, an authority figure, (understandably) wanting to believe that her concerns for her son had been misplaced.

[108] See the Statement of Dr Crameri at exhibit 1(b)

[109] See transcript pages 14 and 56-7.

Further, I find that Mr Chilcott's physical examination of Marcus was less than thorough, and that the failure to record details of the surgical scar to the abdomen, which according to Ms Charles she had specifically pointed out to him, reflects that he failed to consider the possibility of linkage between Marcus presentation and his earlier surgery.[110]

It is also the case that Mr Chilcotts inability to complete the recording of such history as he managed to obtain, should have acted as a further red flag to both himself and Mr Sutherland.[111]

In conclusion, I note that postoperative adhesions leading to bowel obstruction following surgery can occur some time after surgery, and particularly in the case of an infant, can occur suddenly and with dramatic effect.

Even allowing for the (unexplained) non-identification of the earlier bowel surgery by the attending ambulance officer, I find that I am satisfied that Marcus at three months, with a known history of oesophageal surgery at birth, and unexplained vomiting, should have been identified as being vulnerable and immediately transferred to hospital.

I also find that if Marcus had been transported to the RCH, and medically reviewed on 4 November by a Doctor aware of his history, that there was a very good chance of a successful outcome.[112]

I direct that a copy of this finding be provided to the following:
Michelle Charles and Patrick Hall,
Ambulance Victoria
Byron Chilcott
Bruce Sutherland
Dr J Crameri
The Department of Human Services

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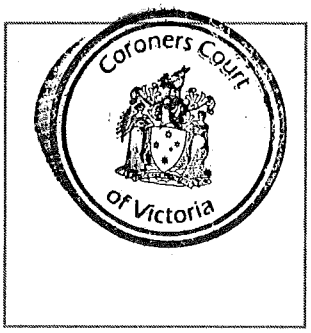
[110] See footnote 106.

[111] I also find that the explanation for the incomplete nature of that recorded history was itself unsatisfactory, as having gained system access Mr Chilcott was obliged to persevere, until satisfied with the record.

[112] See the opinion of Professor Tibballs at transcript page 293-294.

Signature:



PETER WHITE
CORONER
Date: 17 March 2014.