IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 0085

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: RAELENE JEAN SYDDALL

Delivered On:	22 February 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	16 November 2012
Findings of:	JOHN OLLE, CORONER
Police Coronial Support Unit	Leading Senior Constable John Kennedy

I, JOHN OLLE, Coroner having investigated the death of RAELENE SYDDALL

AND having held an inquest in relation to this death on 16 November 2012
at MELBOURNE
find that the identity of the deceased was RAELENE JEAN SYDDALL
born on 1 December 1973
and the death occurred on 8 January 2012
at 12 Trevino Way, Cranbourne North 3977
from:

1 (a) UNASCERTAINED

in the following circumstances:

1. Raelene Syddall was aged 37 years at the time of her death. She lived with her husband, Andrew, and son, Liam, at 12 Trevino Way, Cranbourne North.

Summary of relevant health issues

2. Raelene suffered chronic constipation since the birth of her son on 31 August 2010. Over the course of the four months following her son's birth, Raelene was prescribed a number of laxatives, and had numerous investigations, such as x-rays and ultrasounds; however, there was minimal relief in the constipation symptoms.

3. On the 23 December 2010, Raelene had an appointment with Dr Auteri (general practitioner), who had concerns for Raelene's health, given her abnormal blood test and x-ray results. Dr Auteri arranged a referral for a colonoscopy to occur on 8 January 2011 at The Valley Private Hospital.

4. On 26 December 2010, Raelene presented to the Casey Hospital Emergency Department complaining of abdominal pains. She was discharged home after eight hours once the pain subsided.

5. On 7 January 2011, Raelene was advised to drink three packets of Picolax (an Over-The-Counter bowel preparation), for the planned colonoscopy the next day. The medication was listed in the Centre for GI Health, preoperative instruction sheet which states, "Picolax (3 sachet dose)".

The course of 7 January 2011

6. Raelene self-administered the bowel preparation medicines according to the directions. Raelene's husband Andrew assisted her. There were no concerns and the laxatives were taken in strict compliance with instructions.

7. Raelene's mother Jean arrived at her home at about 5.15pm. She noted that Raelene was sipping water and looked good and happy. She was looking forward to the procedure the following day to alleviate her discomfort. Jean took care of Liam.

8. Andrew left the home at about 6.30pm to collect tea for the evening. In his absence, Raelene took the third sachet pursuant to the instructions.

9. Andrew returned with the evening meal after Raelene had taken the third sachet.

10. At about 8.00pm Raelene felt the laxative was taking some effect and went into the en-suite toilet. Jean remained with Liam in the lounge room and Andrew accompanied Raelene to the toilet. Over the course of the next hour and a quarter until about 9.30pm, Raelene was on/off the toilet and subsequently remained on the toilet. She complained to Andrew of nausea and vomited some bile. He applied a damp cloth as she was feeling over-heated.

11. At approximately 9.30pm, Andrew telephoned The Valley Private Hospital due to some concerns about her presentation. However, he spoke to Wendy Molloy, after-hours nursing supervisor, who assured him the symptoms were not uncommon. Of note, Wendy advised not to continue further intake of the laxative until the nausea abated. Unknown to her, the complete course had been taken by Raelene by 7.30pm.

12. At all times, Raelene consumed water pursuant to instructions. In total, she consumed approximately 6 or 7 x 600mls of water.

13. At about 9.30pm, Raelene had a shower and Andrew assisted her. The water was tepid and she remained in the shower over the next hour to hour and a half. At times, she would squat down to take the weight off her legs and other times she would be upstanding.

14. Between 10.30 and 11.00pm, Raelene's condition deteriorated. In evidence, Andrew acknowledged in hindsight he should have called for Jean's assistance or indeed sought Jean's

opinion as to Raelene's deteriorating condition. In any event, Andrew contacted The Valley Private Hospital who suggested he either take Raelene to a local doctor or to a hospital emergency department, noting Casey or Cranbourne were the closest.

15. Andrew subsequently contacted '000' and requested an ambulance. After a short period of time whilst waiting for the ambulance to arrive, Andrew noticed Raelene's condition had deteriorated further and she was now moaning.

16. Andrew recontacted Ambulance Victoria and requested an emergency ambulance. Paramedics arrived at the house, however, Raelene was not breathing and had no cardiac output. Paramedics immediately commenced CPR and requested an urgent Mobile Intensive Care Ambulance (MICA) to assist. MICA paramedics arrived and continued CPR and intubated Raelene.

17. Regrettably, Raelene did not regain consciousnesses and died at home at about 12.33am on 8 January 2011.

18. I am satisfied that the Picolax was taken by Raelene in strict compliance with the instructions. Raelene consumed fluid as desired and Andrew brought bottled water to her at her request.

Overview

19. Raelene was on the path to undergoing colonoscopy, which is the appropriate medical intervention investigation for unexplained constipation and abdominal pain. It is possible Raelene inadvertently, without the knowledge of herself or Andrew, consumed an excessive amount of water whilst ingesting the bowel preparation.

20. It appears that Raelene was also taking a cold shower for some time without Andrew realising that the hot water had expired.

21. Raelene may have experienced side effects of over-consumption of water without sodium or other electrolytes. If so, there was no reasonable basis for herself or Andrew recognise the seriousness of the symptoms. When Jean saw Raelene in the shower it was apparent that her condition was parlous. Indeed, Raelene appeared unconscious.

22. I am satisfied that insensitive comments made by Andrew in the period following Raelene's collapse were not intentional. The comments were totally out of character and not

representative of the affection Andrew held for Raelene. Regrettably the comments fractured the relationship between Andrew and Raelene's family, in the result that Liam had no contact with his maternal grandparents or family since the tragic death of Raelene. I note in evidence Andrew wishes very strongly that Raelene's family are interlinked involved with Liam and, of course, is an appropriate and desirable course for Liam's best interests.

23. Because Raelene died at home, there are no antemortem laboratory tests to assist the cause of death. In evidence, Jean and subsequently Andrew believe that antemortem blood tests were taken the morning of the 7 January 2011. Extensive searches were undertaken by my assistant, Leading Senior Constable Harrison at both Dr Auteri's surgery and various pathology services. There is no record of any blood tests taken on 7 January 2011.

Post Mortem Medical Examination

24. On 11 January 2011, Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Raelene Jean Syddall.

25. Dr Burke was unable to ascertain the cause of death.

26. Dr Burke commented:

> *"Raelene Syddall was a a 37 year old woman who, according to the circumstances as detailed in the Victoria Police Report of Death Form No. 83, had taken an over the counter medication in preparation for a colonoscopy. She became unwell with vomiting and collapsed. She was unable to be resuscitated.*
>
> *The postmortem examination showed no evidence of any injury that would have contributed to or led to death.*
>
> *The postmortem examination has showed pulmonary oedema. Macroscopic examination of the heart showed prominent fat within the right ventricle however there was no histological evidence of right ventricular dysplasia. There was no evidence of acute infarction or fibrosis. There was no suggestion of myocarditis or granulomas. The conjunction system was unremarkable.*
>
> *Review of electrocardiographs performed in April, 2001 over a four-day period showed changes not diagnostic, but suggestive, of inferior myocardial ischaemia with T-wave*

inversion, flattening with some ST depression in leads 2, 3 and AVF (see separate cardiology report). There were no ischaemic changes seen in the inferior aspect of the heart at post mortem.

The toxicological examination showed normal renal function. There was normal glucose. Amiodarone was detected. Enquiries as to why the deceased had amiodarone showed in her blood showed it had been administered by ambulance personnel.

Raelene Syddall appears to have died from a sudden cardiac arrhythmia whilst taking a routine medication in preparation for a colonoscopy. There was no structural abnormality detected in her heart. One cannot exclude an underlying functional abnormality such as long or short QT syndrome or other rare conduction system problem. As such, the deceased's family has been referred to the Institute's family contact program."[1]

27. I note that Jean and Andrew were unaware of the cardiac history of Raelene. Further, that Jean was unaware of the comments section above in a sense that Raelene appears to have died from a sudden cardiac arrhythmia whilst taking routine medication.

I find the cause of death of Raelene Jean Syddall to be unascertained.

I direct that a copy of this finding be provided to the following:
Mr Andrew Syddall
Constable Maryanne Murphy, Cranbourne Police Station, Investigating Member
Interested Parties

Signature:

JOHN OLLE
CORONER
Date: 22/2/13

Coroners Court of Victoria

[1] Comments section Dr Burke's post mortem report