IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 1703

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Travis Jack Blows
Date of birth:	22 January 2003
Date of death:	12 April 2018
Cause of death:	1(a) pneumonia in the setting of cerebral palsy and epilepsy
Place of death:	Monash Health, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168
Keywords:	Natural causes, child in care

INTRODUCTION

1. On 12 April 2018, Travis Jack Blows (**Travis**) was 15 years old when he died at the Monash Medical Centre. At the time of his death, Travis was under the care of the Department of Health and Human Services (**DHHS**).

THE CORONIAL INVESTIGATION

2. Travis's death 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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Travis's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Travis Jack Blows including evidence contained in the coronial brief. 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.[1]

[1] 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

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

Circumstances in which the death occurred

7. Travis lived with global developmental delay, cerebral palsy, macrocephaly and epilepsy. Travis began attending regular respite care from age seven. In January 2017, Travis was removed from his paternal grandfather's care.

8. In the ten months prior to his death, Travis resided at Jewish Care. Travis had previously resided at Jewish Care for approximately two weeks in March 2017.

9. Travis had several attendances to the Emergency Department (**ED**) at the Monash Medical Centre (**MMC**) in the months immediately prior to his death.

10. On 10 January 2018, Travis presented at ED following a near-choking episode. The issue self-resolved and he was discharged.

11. On 22 January 2018, Travis was experiencing increased seizures, with a background of known epilepsy and an abnormal electroencephalogram (**EEG**) in December 2017. It was noted that it was difficult to determine Travis's usual seizure pattern as he had multiple carers. Travis was known to the neurology department at MMC. Travis's dose of anti-convulsants had been reduced in December 2017 due to sedation and emotional lability. His observations and examination were unremarkable. After consultation with neurology, Travis was discharged with an increased dose of anti-convulsant.

12. On 5 February 2018, Travis had a brief self-terminating seizure. He was otherwise clinically well and was discharged.

13. On 19 February 2018, Travis presented to ED having had seven recurrent seizures that morning. Travis was documented as being sleepy and having a fever. He was then admitted to the Short Stay Unit (**SSU**) for several hours to be monitored. The neurology consultant added a third anti-convulsant medication, sodium valproate. As Travis had remained stable, he was discharged and scheduled to be reviewed in neurology outpatients the next day.

14. On 20 February 2019, Travis had two seizures in the morning. Travis's carers were worried as Travis was more tired and lethargic than usual. Travis was reviewed by the neurology team

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

who were of the view that he did not require admission. Travis was given increased doses of anti-convulsants and was scheduled for outpatient review. A rehabilitation admission was planned for 5 March 2018. At the time of discharge, it was noted that Travis went back to his baseline.

15. On 24 February 2018, Travis had a further seizure and was noted to have a temperature and elevated heartrate. A blood test showed a markedly elevated sodium level of 160. Travis's sodium level had been normal on 19 February 2018. He had a short admission to the Paediatric Intensive Care Unit (**PICU**) and was then transferred to the ward. His elevated sodium was treated with intravenous fluids and quickly normalised. He underwent a number of specialised investigations to try and determine the cause of his neurological deterioration. Travis was treated with intravenous antibiotics for a presumed urinary tract infection. Unfortunately, in the setting of a general anaesthetic for a Magnetic Resonance Imaging (**MRI**) scan on 9 Mach 2018, Travis's respiratory status deteriorated, and he required transfer back to PICU.

16. Travis was initially treated with non-invasive ventilation and intravenous antibiotics to treat ongoing fever, now thought to be due to aspiration pneumonia. He continued to have 50 to 60 prolonged seizures daily which were difficult to control despite multiple anti-epileptic medications. Travis continued to have ongoing fevers of an unclear cause despite ongoing investigations and different antibiotics.

17. Travis was intubated on 15 March 2018 due to ongoing respiratory failure and fatigue. Despite full active therapy and consultation with multiple specialist teams, his condition continued to decline. In consultation with the PICU and medical teams, it was decided that further active therapies would be futile, so permission was obtained from DHHS to withdraw active treatment. Travis was declared deceased on 12 April 2018.

Identity of the deceased

18. On 12 April 2018, Travis Jack Blows, born 22 January 2003, was visually identified by his carer, Robyn Scott.

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

Medical cause of death

20. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 17 April 2018 and provided a written report of his findings

dated 22 August 2019. Dr Lynch also reviewed the Victoria Police Report of Death (**Form 83**), the contact log, the post-mortem computed tomography (**CT**) scan, medical records and deposition from MMC and a letter expressing concerns from Irene Defasa, Travis's aunt.

21. The post-mortem examination revealed there were a number of significant natural diseases present. There was evidence of widespread confluence bronchopneumonic change involving the right middle and lower left upper and lower lung lobes. Neuropathological examination revealed mild encephalomegaly with communicating chronic hydrocephalus, focal cerebellar folial dysplasia and an incidental colloid plexus cyst. The neuropathologist noted that there were no acute neuropathological changes that might account for Travis's death.

22. Toxicological analysis of post-mortem samples identified the presence of anti-convulsants clobazam and levetiracetam. Paracetamol was also detected.

23. Dr Lynch provided an opinion that the medical cause of death was 1 (a) pneumonia in the setting of cerebral palsy and epilepsy. Dr Lynch concluded that Travis's death was due to natural causes.

24. I accept and adopt Dr Lynch's opinion.

CPU REVIEW OF CARE

25. Travis's death was referred to the Health and Medical Investigation Team (HMIT) within the Coroners Prevention Unit (CPU).[2]

26. Concerns were raised by Travis's maternal aunt, Irene Difesa, Robyn Scott, Travis's kinship carer who permanently lived with him, and Fiona Downing from the Youth Disability Service.

27. Largely the concerns related to the quality of care Travis received at Jewish Care and how he had arrived at hospital in such a dehydrated state. Ms Downing had previously raised concerns with the Children's Commissioner, the Disability Services Commissioner, the Victorian Ombudsman and the Manager of the Quality Team in the South Division of DHHS.

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

28. Travis had a severe disability with epilepsy that was difficult to control. He had four attendances to the Emergency Department shortly prior to his death, where he presented with seizures. The CPU considers his management on these occasions was appropriate with investigations performed and neurology consulted as required.

29. On 24 February 2018, when the elevated sodium was detected, he was admitted to the PICU. Travis's subsequent management was reasonable to try and determine the cause for his fever and increased seizures. Travis would have required a general anaesthetic for an MRI scan as he would not have been able to lie still for the length of time required to perform the scan. Unfortunately, this precipitated further respiratory deterioration and readmission to PICU. This was initially managed with non-invasive ventilation but then due to ongoing respiratory failure and fatigue, Travis required intubation and ventilation.

30. Travis sustained a pneumothorax (punctured lung) when he was intubated. This is a common serious complication of mechanical ventilation due to increased airway pressure in the lung, often occurring in patients with pre-existing lung disease, as in this case. It was successfully treated by inserting a draining tube. Travis's condition continued to deteriorate despite maximal medical therapy. There were many family meetings documented during his stay in PICU.

31. CPU considered that the medical care Travis received at MMC was appropriate, with no opportunities for intervention or improvement identified. Travis had a severe disability and, for unclear reasons, developed up to 60 seizures per day which were difficult to control. No cause was found at autopsy for his neurological deterioration.

32. CPU noted that the Commission for Children and Young People (**CCYP**) undertook an inquiry into the death of Travis pursuant to section 34 of the *Commission for Children and Young People Act 2012*. CCYP compiled a report into Travis's death.

33. CCYP's report raised a number of valid findings and recommendations, however none of the important matters raised in that report are coronial matters, and cannot directly be linked to Travis's cause of death.

FINDINGS AND CONCLUSION

34. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Travis Jack Blows, born 22 January 2003;

b) the death occurred on 12 April 2018 at Monash Health, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168, from pneumonia in the setting of cerebral palsy and epilepsy; and

c) the death occurred in the circumstances described above.

35. I am satisfied that Travis's death was due to natural causes.

Pursuant to section 73(1B) of the Act, I order that 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:

Vicki Grant, Senior Next of Kin

Robyn Scott, Carer

Josephine Blows, care of Michelle Cavalieri, Arnold Thomas & Becker Lawyers

Stefan Blows, care of Katie Schultz, Slater and Gordon Lawyers

Liana Buchanan, Commission for Children and Young People

Thomas Kuster, Department of Health and Human Services

Sergeant Dao Bui, Coroner's Investigator

Signature:

Coroner John Olle

Date : 3 October 2022

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.