IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006991

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE PASSING OF BCT

Findings of:	Coroner Katherine Lorenz
Delivered On:	30 October 2023
Delivered At:	Coroner Court of Victoria 65 Kavanagh Street Southbank Victoria 2006
Hearing Dates:	24 October 2023
Representation:	Cassandra Nolan representing the Department of Families, Fairness and Housing Peter Ryan representing Monash Health
Counsel Assisting the Coroner:	Dr Declan McGavin, Coroner's Solicitor, instructed by Sonja Mileska, Senior Coroner's Solicitor
Keywords	Aboriginal Passing, Therapeutic Foster Placement, Hospital, Paediatric

INTRODUCTION

1. On 30 December 2021, BCT was 2 years old when he passed away at Monash Medical Centre, Clayton. At the time of his passing BCT lived with his foster carer, EL. BCT had resided with EL for 18 months and was planned to spend supervised time with his mother, DY each fortnight.

2. FP was BCT's father and had not spent time with BCT since 2020.

3. BCT had complex health needs relating to a genetic disorder subsequently identified as a CAMTA1 compound heterozygous pathogenic mutation. This manifested as:

    a) Profound hypotonia and areflexia.
    b) Auditory sensory neuropathy with bilateral hearing aids.
    c) Delayed visual maturation.
    d) Global developmental delay.
    e) Significant upper gastrointestinal (GI) dysmotility.
    f) Velopharyngeal incompetence with possible aspiration risk.
    g) Dysmorphic features (tented upper lip, high arched palate, micrognathia, crowded and overlapping toes).

4. As a result of the significant GI dysmotility, BCT had a percutaneous endoscopic gastrostomy (**PEG**) tube for feeding and hydration.

THE CORONIAL INVESTIGATION

5. BCT's passing 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 'in care', which includes BCT as a foster child in long-term out of home care as subject to a Care by Secretary Order (**CBSO**)[1] dated 22 April 2021.

6. The Act recognises that people 'in care' are vulnerable and affords them protection by requiring that the circumstances of their passing are investigated by a coroner, irrespective of

[1] A CBSO gives parental responsibility for a child's care to the Secretary of the Department of Fairness, Families and Housing or delegate to the exclusion of all other persons. This order is made for a period of two years. A CBSO is appropriate when a child has been in an out-of-home care for a period of 24 months, or earlier where it has been determined that a child will not be able to safely return to the care of the parent and the appropriate permanency objective is adoption, permanent care, or long-term out of home care.

the medical cause of death, and by mandating that as part of that investigation there should be an inquest or formal public hearing unless it is a death from natural causes.

7. 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.

8. 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.

9. This finding is based on the Coronial Brief and the submissions of counsel who appeared at inquest. It is unnecessary to summarise all of this material. It will remain on the Court file, and I will refer only to so much of it as is relevant or necessary for narrative clarity.

10. In the coronial jurisdiction, facts must be established on the balance of probabilities.

BACKGROUND

11. BCT was the only child of DY and FP, who are both Aboriginal.

12. BCT was born in Queensland and was known to Queensland Child Safety Services (**QCSS**) from when he was an infant.

13. In or around November 2019, DY and BCT moved to Melbourne, Victoria, with the support of BCT's maternal grandmother.

14. On 6 December 2019, a report was made to Child Protection Victoria (**CPV**). At the time of the report, BCT had been in the Monash Children's Hospital (**MCH**) since 21 November 2019. DY had taken BCT to MCH as BCT was having seizures.

15. CPV investigated the report. According to the DFFH, DY and BCT's maternal grandmother reportedly advised CPV that they were not able to take on the full range of care needs BCT required, and that it was best for BCT to be placed in an out of home care placement where these significant needs could be met.

16. Subsequently, BCT was provided with a Therapeutic Foster Placement[2] with Anglicare Victoria (**Anglicare**). Anglicare was responsible for the specialised recruitment, supervision, and training of EL and the provision of enhanced placement support. Anglicare worked in partnership with Australian Childhood Foundation[3] which provided therapeutic assessment, guidance, and support to placement to facilitate and support the care of BCT.

17. BCT was supported by a team of health professionals from MCH including a paediatrician, a neurologist, a geneticist, an audiologist, and a gastroenterologist. BCT was a National Disability Insurance Scheme (**NDIS**) participant with a package coordinated by Red Umbrella[4] and linked to his local general practitioner.

18. BCT's care team included: CPV, Victorian Aboriginal Child Care Agency (**VACCA**), the medical team from MCH, an occupational therapist from Eastern Health, an audiologist from Hearing Australia, a physiotherapist, a speech pathologist, Anglicare, EL, and a NDIS support coordinator from Red Umbrella.

19. CPV retained case management and decision-making responsibility for BCT. In consultation with Anglicare, VACCA and based upon medical information, CPV developed and implemented a case plan that would best meet his needs. The case plan included:

    a) VACCA to provide cultural supports with a cultural support plan to maintain connection to community and ensure cultural safety.

    b) Supervised contact with DY and FP twice a month.

    c) The team from MCH to co-ordinate and deliver BCT's health needs.

    d) NDIS, with Anglicare, to co-ordinate BCT's developmental needs across social, emotional, and physical domains.

20. The health team from MCH provided close monitoring and oversight of BCT. The health practitioners in the care team provided expert advice on BCT's complex health needs which

[2] Therapeutic foster care is a program of home-based care for a child that places emphasis on stability and provides additional supports for the child and carers. Key features of the program are the centrally important role of the care team, the support to the child and the carer and the dedicated involvement of both placement and therapeutic specialist providers

[3] A specialist therapeutic support service

[4] Red Umbrella is a service that provides NDIS support coordination to kids and teens and their families.

included planning hospital visits and admissions for ongoing treatment. In an emergency, EL was to take BCT to the emergency department at MCH as soon as possible.

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

Circumstances in which the death occurred

21. On 23 November 2021 BCT attended a paediatric gastroenterology outpatient appointment at MCH with EL. The purpose of this appointment was to discuss and arrange an elective conversion of a PEG to a percutaneous endoscopic gastrojejunostomy (**PEG-J**).

22. The procedure was necessary due to ongoing issues related to BCT's significant upper GI dysmotility including gastro-oesophageal reflux, vomiting, and aspiration pneumonia. Where a PEG allows for feeding directly into the stomach via a tube through the abdominal wall, a PEG-J extends this tube into the small intestine to also bypass the stomach to avoid these issues. The procedure was scheduled for 10 December 2021 at MCH.

23. On the day, EL signed the consent form for the PEG to PEG-J procedure to be performed and at 2.55pm, the procedure commenced and performed by two Interventional Radiology (**IR**) fellows and an IR consultant. There were no complications documented in the procedure report.

24. At 6.35pm, BCT was transferred from the recovery ward post procedure to the ward. The admission note documented that the PEG-J site was 'red, but evolving inflammation rather than acute or infective' and mild feeds were commenced.

25. Between 10 December 2021 and 13 December 2021, BCT remained in the ward. There were some initial concerns with feed tolerance and gagging. At 6.00am on 13 December 2021, BCT had a small vomit, and at 12.51pm a nursing note identified that BCT was becoming more unsettled than normal which could not be alleviated by venting the PEG-J. On examination, the insertion site was red and crusted. BCT was given paracetamol and domperidone and an abdominal Xray (**AXR**) was ordered.

26. The gastroenterology resident and IR fellow reviewed the AXR and identified that the tip of the PEG-J was incorrectly positioned and overlying the proximal duodenum. The IR fellow was concerned that it may migrate again after repositioning but was willing to reposition the tube anyway under general anaesthetic the following day. The IR fellow reportedly suggested

that the PEG-J not be used in the meantime, however, this was not documented by either clinician in the EMR.

27. BCT's level of distress increased during the day and EL advised staff that his crying sounded like he may be in pain. At 5.55pm the PEG-J balloon was deflated and re-inflated to reduce his discomfort. An examination of the abdomen found no acute concerns. BCT's usual feed regime was recommenced with a plan to change to Oral Rehydration Solution (**ORS**) at midnight to fast before theatre.

28. At 7.34pm the PEG-J was leaking feed and EL was concerned that BCT was more unsettled and having jerky movements and frequent mucus spit ups. Examination showed BCT had a low-grade temperature and was tachycardic with a heart rate of 188bpm which fell into Medical Emergency Team (**MET**) call criteria. The MET is a team of specialised doctors and nurses who respond immediately to a call for urgent medical help. This call can be triggered by abnormal clinical observations, such as occurred in this instance, or general concern by nursing or medical staff.

29. The MET reviewed BCT and ceased feed via the PEG-J and instead commenced ORS at a maintenance rate. The team ordered a set of blood tests and a COVID swab and BCT was placed in COVID isolation area pending these results.

30. At 8.56 pm, BCT's heart rate had increased to 199 beats per minute, blood pressure was 108/70 mmHg, oxygen saturation was 96%, and temperature was 35.9°C. Another MET call was made.

31. The call was attended by the Paediatric ICU (**PICU**) Outreach Clinical Nurse Consultant (**CNC**), the Gastroenterology Fellow and Registrar, and ward nursing staff. A paediatric intravenous catheter (**PIVC**) was inserted with bloods taken for investigation. ORS via the PEG-J was ceased and maintenance fluids through the PIVC were commenced instead. An Xray was performed as part of septic screening.

32. At 11.50pm, BCT's heart rate remained elevated, and his temperature was 38°C which resulted in another MET call. This call was attended by the PICU Outreach CNC, the Paediatric Registrar and Resident, and ward nursing staff. The combination of fever, hypovolaemia, and pain made the team query if sepsis was the cause for the ongoing tachycardia. As such, BCT was given a 100ml bolus of fluid through the PIVC, paracetamol, oxycodone. A urine MCS was requested to complete the septic screen.

33. The team reviewed the results from blood taken at an earlier MET call which showed an elevated white blood cell count which suggested possible infection. The results were escalated to the Gastroenterology Fellow on call who ordered ceftriaxone and metronidazole which are broad-spectrum antibiotics that would cover possible intraabdominal infection.

34. At 12.52 am, 14 December 2021, EL advised the nursing staff that BCT's cot sheet and blanket were wet. On examination, the PIVC had dislodged, and it was unknown how much of the bolus and ongoing maintenance fluids had been administered. The medical resident was paged to re-site the PIVC.

35. On attendance, the resident made multiple unsuccessful attempts to re-site the PIVC and documented a plan to reassess in the early morning. On advice from the paediatric registrar, ORS was recommenced via the PEG-J. The antibiotics had not yet been given and the ceftriaxone was recharted to be given intra muscularly (**IM**) which occurred at 4.38am. Metronidazole is unable to be given IM and was thus not administered.

36. At 5.16am, a third MET call was required for ongoing tachycardia, BCT's heart rate was now 230bpm. The call was attended by the PICU outreach CNC, Paediatric Registrar and Resident, and ward nursing staff. In addition, a member of the anaesthetic team attended to re site the PIVC. This was successful and BCT was given metronidazole (the antibiotic), a fluid bolus, and commenced on maintenance fluid therapy.

37. At 7.46am, a fourth MET call was required for seizure activity of jerking of upper and lower limbs and a reduced conscious state. On examination, BCT's oxygen saturation was 78%, temperature 38.3°C, and remained tachycardiac. Point of care testing showed severe hypoglycaemia (low blood sugar) which was treated with a fluid bolus of iv dextrose solution.

38. Also during the MET call, BCT required ventilatory support due to ineffective breathing. BCT was also given buccal midazolam and the seizure activity ceased. While BCT's conscious state and blood glucose level improved, he still required analgaesia and looked unwell. As such, the PICU consultant attended. After review, an impression of 'sepsis of unknown source' was documented in the medical record and BCT was transferred to the PICU.

39. At 9.04 am, BCT arrived at PICU and was immediately intubated and required medications to maintain his blood pressure.[5] The associated lines to monitor blood pressure and administer these medications were also inserted and the placement of these lines and endotracheal tube

[5] This therapy included inotropes and vasopressor.

were confirmed on chest and abdominal Xray. The PEG-J was vented which resulted in a recorded output of 50-60ml of faecal matter.

40. At 1.30pm, the PICU Registrar contacted the Paediatric Surgical Registrar who advised that considering the faecal output, a likely diagnosis was ileus or a bowel perforation and as such, recommended a CT scan of the bowel. The antibiotics were ordered to continue until BCT was well enough for transport to the radiology department for the CT scan.

41. At 2.21pm, an abdominal ultrasound was requested as BCT remained too unstable for transport to the radiology department for the CT scan. This was performed in the PICU at 4.30pm and identified large volume extensive complex intraperitoneal free fluid, consistent with a bowel perforation.

42. At 5.30pm, the Surgical Registrar reviewed BCT who advised that they would return with their consultant and to continue PICU care and place the PEG-J on free drainage in the meantime. The consultant review occurred at approximately 8.30pm, and the Paediatric General Surgery Consultant documented a plan for an urgent exploratory laparotomy. Consent for this surgery was provided by GM in her capacity as a Child Protection Team Manager from the Outer East Melbourne Area.[6]

43. At 12.20am on 15 December 2021, the exploratory laparotomy commenced and identified a duodenal perforation. Surgeons repaired the perforation and washed out the abdomen. On return to the PICU, BCT's cardiovascular function improved significantly and the additional medications for blood pressure support were successfully weaned over the following 12 hours.

44. Three days later, on 18 December 2021, at 9.00am, BCT was extubated. However, over the course of the day, BCT deteriorated and required non-invasive ventilation for several hours. At 7pm, BCT required reintubation because of reduced consciousness and abnormal neurology including suspected seizure activity.

45. On 19 December 2021, an electroencephalogram (**EEG**), detected that BCT has minimal electrical activity in the brain. Magnetic Resonance Imaging (**MRI**) showed findings consistent with severe global hypoxic injury. However, the report strongly recommended correlation with results of a lumbar puncture to exclude the possibility of encephalitis (inflammation of the brain). This was performed the next day and excluded encephalitis.

[6] The legal mechanisms of this consent process is explored below.

46. Later that day, on 20 December 2021, a family meeting was held to discuss the BCT's prognosis. Clinicians provided an opinion that BCT had sustained a significant brain injury from which he would not recover. After the meeting, BCT's care shifted to a palliative approach and at 2pm on 21 December 2021, BCT was extubated. From this time, both DY and EL were present at the bedside at various times until BCT's passing.

47. At 6.50am on 30 December 2021, BCT passed away in the presence of EL.

Identity of the deceased

48. On 30 December 2021, BCT, born 8 September 2019, was visually identified by EL, his foster carer, who had cared for BCT for 18 months and signed a statement of identification.

49. Identity was not disputed and required no further investigation.

Medical cause of death

50. Forensic Pathologist Dr Yeliena Baber (**Dr Baber**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 31 December 2021 and provided a written report of the findings dated 10 January 2022. In preparation of the report, Dr Baber also considered the Police Report of Death (Form 38), VIFM contact log, the E-Medical Deposition from MCH, and a post-mortem CT scan.

51. The external examination showed findings in keeping with the clinical history. The CT scan showed patchy bilateral cerebral ischemia in watershed areas and non-specific patchy increase in lung markings.

52. Dr Baber provided an opinion that the medical cause of death was 1(a) *Hypoxic-ischaemic encephalopathy following sepsis related to abdominal surgical procedure* 1(b) *CAMTA1 mutation progressive cerebral palsy*.

53. I accept Dr Barber's opinion.

FURTHER INVESTIGATION

Monash Children's Hospital Review of Care

54. In response to BCT's passing, a multiple disciplinary team at MCH performed a root cause analysis (**RCA**) to identify any system or process improvements related to the case. A report of the findings was submitted to Safer Care Victoria (**SCV**) as a sentinel event.

55. The report identified that the main issue was a delay in recognising the bowel perforation and subsequent sepsis. There was a failure to consider perforation as a cause of BCT's clinical deterioration which delayed effective resuscitation, escalation, and early involvement of surgical teams. The report highlighted four critical points with twelve findings where earlier intervention may have resulted in a different outcome for BCT and made thirteen recommendations to address these.

56. At my request, the Chief Legal Officer of Monash Health, Peter Ryan (**Mr Ryan**) wrote to the court on 27 April 2023 and again on 17 August 2023 to advise on the implementation of these recommendations. Mr Ryan provided a final update via email on 18 October 2023.

Critical points 1 and 2: Lack of communication of the difficulty of the procedure and not investigating or considering perforation as the cause of clinical deterioration

57. Bowel perforation in this procedure is rare and would not have been considered a likely outcome. However, had the degree of difficulty been communicated or better documented by interventional radiology to the treating team, then bowel perforation may have considered more likely and/or considered earlier.

58. Cognitive bias contributed to the decision not to detail the degree of difficulty but there was also no standardised model to report any difficulties or complications nor routine handover post-procedure. There was also no procedure for formalised reporting of post-operative complications back to the IR proceduralist.

59. Cognitive bias also contributed to why this diagnosis was not considered by the medical team. There was an inadequate understanding of the unexpected degree of difficulty by the medical team which if conveyed, may have led them to consider this as a cause of the BCT's decline.

60. A cognitive bias action plan was already being developed following another sentinel event so the report recommended to continue progression of this. Mr Ryan advised that a Grand Round recorded presentation on cognitive bias has been completed and is available for ongoing education. Cognitive bias is also included within HMO deteriorating patient curriculum and intranet page. The final outstanding task of a targeted cognitive bias training module is in development but has been delayed and is instead expected by the end of November 2023.

61. The report recommended that IR work with EMR to develop a template for procedural reporting. A standardised template has been developed which captures difficulties or adverse events and has been fully implemented to be used in all radiology procedures.

62. Further, when an adverse event occurs, this is verbally handed over by the radiology team to the treating team.

Critical Point 3: Delay in resuscitation

63. The PEG-J was continued to be used for feeds and for ORS after migration of the tube was identified. This would have contributed to peritoneal soiling and thus delayed sepsis control. The IR fellow advised the gastroenterology resident over the phone to not used the migrated tube until it could be repositioned. However, this advice was not documented in the EMR by either clinician.

64. The report found that documentation of specialist advice is not embedded in practice and recommended a requirement for specialist teams to document in person and phone advice in the EMR. This was completed on 17 February 2023.

65. There was also a delay in recognising loss of IV access and delay in replacement. This was contributed by a failure to recognise the severity of BCT's condition. The report identified that competing and excessive workload demands on nursing staff and the overnight paediatric registrar and resident contributed to this delay. This also contributed to not recognising hypoglycaemia until much later.

66. The report also found that the lack of senior staff involvement contributed to the delay to resuscitation and recognition of severity of illness. There was inadequate escalation to senior medical staff on call and non-adherence to MET call procedure. This was contributed by poorly defined referral pathways overnight; the report found that the current MET call model of care for paediatric patients was inadequate in its current form.

67. The report recommended the childrens program review the overnight nursing model of care, review and update escalation to consultant procedures particularly overnight and in the context of MET calls.

68. These have since been implemented and now:

    a) Any delay of care is an automatic escalation to a consultant.
    b) All MET calls are escalated to a Consultant.
    c) PICU consultations should be discussed with a consultant as soon as possible after the consult is received.

d) Surgical consults in PICU must be seen as soon as possible by the registrar and escalated to the consultant.

69. Monash Health have also since clarified the role of the PICU Clinical lead in MET calls including reporting of the MET call events overnight directly in the EMR and advising the PICU Registrar. Finally, the PICU Outreach has been expanded to a 24-hour service, with the PICU MET call Registrar coverage now in line with models at other sites. There is an additional resident rostered on overnight to reduce the individual workloads of junior doctors.

Critical Point 4: Delay to Surgery

70. In addition to the issues related to the delay in consideration of bowel perforation, the report also found ineffective communication between the PICU and surgical team, and a delay in escalation to the surgical consultant.

71. The report recommended review and update of the surgical handbook to align with the paediatric escalation to consultant procedure and the medical consult procedure which has since been implemented.

Other concerns and recommendations

72. The report noted that while the procedure was discussed in detail with EL at the prior outpatient appointment, the legal consent process was undertaken immediately prior to the procedure by the IR Fellow in the waiting bay. There was no documentation of the consent process other than the signed consent form and it is not clear if the BCT's Child Protection worker or DFFH were involved in the consent process which the report recognised as a legal requirement.

73. The report determined that the consent process for the procedure was insufficient in this case and recommended review and update of the consent to medical treatment procedure to include consents in the setting of Childrens Court Orders. This was completed on 26 July 2023 and endorsed by the Children's Program Clinical Governance Committee and the Vulnerable Children's Committee. The updated procedure was approved by the Clinical Council in August 2023 and has been uploaded to the policies and procedures platform and disseminated to medical staff.

74. Finally, the report determined that there was a failure to act on the ongoing concerns voiced by EL which was linked to the under recognition of the severity of BCT's illness. This was a key learning and was incorporated into the implementation of the related recommendations.

75. Other recommendations included:

    a) Diagnostic imaging to review and implement a governance process for Gastrostomy/jejunostomies inserted by Interventional Radiology and establish a database including associated complications.
    b) Review the currently available Gastrostomy/Jejunostomy procedures in prompt and update to ensure they adequately cover paediatrics.
    c) Direct instructions to improve care of patients undergoing procedures including development of pre-procedure assessment and consent process and development of post-procedure care and review process.
    d) Program to ensure learnings are shared with relevant employees.
    e) Program to work with patient experience officer to complete open disclosure.

76. Except for this first recommendation, these additional recommendations have all since been implemented. Mr Ryan advised that this first recommendation is a large body of work and has been extended to early 2024. Progress in the meantime includes that IR morbidity and mortality meetings are now in place, and an additional junior staff position has been created and is advertised for recruitment.

77. A clinical space has been dedicated to IR and is intended to bring IR informed consent procedures in line with the current organisational processes for informed consent. A business case is being prepared for clerical and nursing staff for this clinic is currently being prepared, but the clinical is expected to commence in early 2024. Monash Clinical Council have approved the principle of a stand-alone IR bedcard, with implementation of this aimed for early 2024.

Consent

78. On 21 January 2022, the Court wrote to the Department of Families Fairness and Housing (**DFFH**) to ascertain the legal mechanisms under which consent for the two surgical procedures was provided for the BCT.

79. In correspondence dated 4 March 2022, the Area Operations Manager of DFFH was silent on the issue of consent for the surgical procedure on 10 December 2021 and advised that a team manager provided consent on 14 December 2021.

80. On 3 March 2023, the Court wrote to DFFH for a second time. On 31 March 2023, Solicitor Cassandra Nolan (**Ms Nolan**) replied in an email to the Court.

Consent for the scheduled procedure on 10 December 2021

81. Ms Nolan stated that EL provided consent for the elective conversion of a PEG to a PEG-J on 10 December 2021. Ms Nolan outlined that section 175B of the *Children Youth and Families Act 2005* (Vic) (**CYFA**) allowed the CEO of Anglicare Australia in their capacity as the person in charge of an out of home care service to authorise EL to make decisions in relation to BCT. The instrument of authorisation was included in the correspondence from DFFH. This is dated 17 May 2022 which was submitted to be a typographical error and likely signed on 17 May 2021.

82. Section 175A of the CYFA allows the Secretary to specify the kinds of issues relating to a child in out of home care about which a person may be authorised to make decisions. These specifications were provided in the form of an attachment to the instrument of authorisation. Unfortunately, neither DFFH nor Anglicare could locate a copy of the exact attachment included with this instrument. In lieu of the actual attachment, the DFFH provided an example of what this would have been.

83. The specified issues include routine medical and dental care with reference to the day-to-day treatment or following a health management plan for a diagnosed serious health condition or chronic health condition. Non-routine medical care and long-term health decisions are specifically excluded, for example, a dental filling. Major long-term issues are also generally excluded which includes decisions about long-term healthcare.

84. It is clear that BCT required the procedure and, in the circumstances, EL was the most suitable person to make this decision in the best interests of BCT at the time.[7] EL was able to be authorised to provide consent by a different legal mechanism; as submitted by DFFH, an

[7] In subsequent correspondence from Anglicare Victoria, they provided clear evidence of the procedure being discussed with the broader carer team, including DFFH, as well as a plan for DFFH to provide consent to the procedure. It is not clear why this plan did not eventuate; however, this is outside the scope of the coronial jurisdiction to investigate any further as it is not sufficiently proximate nor causative to BCT's passing.

executive with delegated power to make authorisations under section 597(3) by the Secretary could have authorised EL to provide consent.

85. In consideration of BCT's complex health issues, his requirement for acute clinical care, and that there was case discussion with the care team and DFFH, I am not concerned about the issue of consent for care in this case.

Consent for the emergency procedure on 15 December 2021

86. Ms Nolan provided a copy of the signed consent form to the Court. Consent was provided by GM, a Child Protection Team Manager, as the legal guardian of BCT.

87. Under an instrument of delegation in force at the time and issued by Sandy Pitcher, Secretary to the DFFH on 9 February 2021, child protection practitioners at level CPP5-6 are authorised to provide consent for surgical procedures pursuant to section 597(3) of the CYPA. Therefore, I accept that GM, in her capacity as Child Protection Team Manager (CPP5), had the lawful authority to sign the consent form and provide consent for the exploratory laparotomy.

FINDINGS AND CONCLUSION

88. Pursuant to section 67(1) of the Act I make the following findings:

    a. the identity of the deceased was BCT, born 8 September 2019;

    b. the death occurred on 30 December 2021 at Monash Children's Hospital, 246 Clayton Road, Clayton, Victoria, 3168, from *1 (a) Hypoxic-ischaemic encephalopathy following sepsis related to abdominal surgical procedure 1(b) CAMTA1 mutation progressive cerebral palsy*; and

    c. the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

89. I am satisfied that the findings and recommendations from the review by Monash Health both negate the need for further investigation and for me to make any further recommendations. I note that there are two outstanding recommendations that have yet to be fully implemented; these are the development of a learning module on cognitive bias and for a stand-alone bedcard and clinical space for Interventional Radiology.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) I recommend that Monash Health fully implement their outstanding recommendations by:

a. Providing a clinical space with the relevant support staff for Interventional Radiology to review patients and gain informed consent before any procedures; and,

b. Providing Interventional Radiology a stand-alone bedcard with associated staff to facilitate all hours, in-house, and ward-based care.

c. Develop and implement a learning module on Cognitive Bias

I convey my sincere condolences to BCT's family for their loss.

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

DY & FP, Senior Next of Kin

Peter Ryan, Monash Health

Rachael Ritchie, Slater and Gordon Lawyers

Department of Fairness, Families and Housing

Liana Buchanan, Commission for Children and Young People

Leading Senior Constable Timothy Wogan-Browne, Coroner's Investigator

Signature:

Coroner Katherine Lorenz

Date : 31 October 2023

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.