IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002242

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Helen Mahlis
Date of birth:	12 July 1936
Date of death:	22 April 2024
Cause of death:	1a : Oesophageal perforation following an elective oesophageal dilatation 1b : Achalasia
Place of death:	Epworth Richmond 89 Bridge Road Richmond Victoria 3121
Keywords:	Oseophageal perforation, balloon dilation, delayed diagnosis, unavailable equipment, resourcing

INTRODUCTION

1. On 22 April 2024, Helen Mahlis was 87 years old when she died at Epworth Hospital after sustaining an oesophageal perforation following an elective oesophageal dilation. She is survived by her husband, Michael and children.

Medical History

2. Helen had a complex medical history including hypertension, type 2 diabetes mellitus, vascular dementia, transient ischaemic heart attacks and ischaemic heart disease. She also had achalasia - an oesophageal disorder that causes functional obstruction at the gastroesophageal junction. When untreated, achalasia can lead to complications that may be life threatening.

3. Helen had previously received treatment for her achalasia that included a Botox injection through a gastroscopy. A Botox injection is an effective short-term therapy however patients frequently experience a return of symptoms, and repeated injections are known to be less efficacious. These injections can also lead to the development of fibrosis making other treatments more difficult.

4. In 2023 Helen and her daughter, Rosemary, met with specialist surgeon, Dr Peter Prichard (**Dr Prichard**) to discuss her increasing difficulty swallowing. Dr Prichard discussed the management options including pneumatic (balloon) dilation of the oesophagus. The dilation procedure is intended to disrupt the musculature of the distal oesophagus. Dr Prichard noted a 5% risk of perforation which can be fatal.

THE CORONIAL INVESTIGATION

5. Helen'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.

6. 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.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Helen Mahlis 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]

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

Circumstances in which the death occurred

9. On 22 March 2024, Helen was admitted to Epworth Hospital Richmond (**Epworth**) for a gastroscopy and oesophageal balloon dilation.[2] Once Dr Prichard had performed the dilation, he *'drew back the endoscope to perform an inspection and observed a mucosal tear'*. A mucosal tear is not uncommon following dilation procedures.

10. Dr Prichard did not identify a perforation at this time. He ordered a chest x-ray to check for a gross perforation given the mucosal tear and before commencing Helen on a soft-food diet. He described that '[his] suspicion level for a gross perforation was not high given the findings of [the] inspection' and that the x-ray was *'precautionary'*.

11. Following the procedure, Helen reported chest discomfort. From the x-ray, Dr Prichard identified consolidation which he determined was *'old'* but no other abnormalities.

12. Helen initially improved clinically and her chest pain resolved. However, she soon after demonstrated a functional decline, had an elevated inflammatory marker on blood tests,[3] and her chest pain returned. On 25 March 2024, she further declined and exhibited a drop in her haemoglobin count. Clinicians administered a blood transfusion.

13. By this time, Dr Prichard *'became suspicious of a perforation'* and discussed the most appropriate imaging with a radiologist. A barium swallow test was performed which *'reported*

---

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

[2] I note that the procedure had been booked and cancelled on three previous occasions; 1 July, 29 August and 31 October 2024.

[3] The C-Reactive Protein (**CRP**).

no evidence of perforation'. The following day, Dr Prichard ordered a computed tomography (**CT**) of the chest with oral contrast, it showed a distal oesophageal perforation.

14. A left chest drain was inserted, and intravenous antibiotics were administered. Helen was referred to an upper gastrointestinal surgeon, Associate Professor Gary Crosthwaite (**A/Prof Crosthwaite**) who recommended Total Parenteral Nutrition (**TPN**)[4] and all oral medication was ceased. On 27 March 2024, A/Prof Crosthwaite inserted an oesophageal Endo-Vacc (Endoscopic Vacuum Assisted Closure) to attempt to address the perforation.

15. On 28 March 2024, Helen had an elevated blood sugar level (**BSL**), and she was referred to physician, Dr Andrew Talbot (**Dr Talbot**) for insulin. On 30 April 2024, she appeared drowsy and had an elevated BSL – a Medical Emergency Team (**MET**) call was initiated. Helen's insulin dose was increased, and she was provided with increased intravenous fluids.

16. On 1 April 2024, a further MET call was made due to pain at the site of the left chest drain and Helen was provided morphine.

17. On 2 April 2024, Helen's treating team discussed her status with Intensive Care Unit (**ICU**) clinicians and her suitability for escalated treatment. Due to her frailty, Helen was not suitable for any surgical or endoscopic procedures.[5]

18. Over the following days, clinicians discussed Helen's prognosis with her family including her poor outcome and deterioration. She was gradually transitioned to a comfort pathway including the removal of the Endo-Vacc. At 5:12am on 22 April 2024, Helen was declared deceased.

Identity of the deceased

19. On 22 April 2024, Helen Mahlis, born 12 July 1936, was visually identified by her son, Emmanuel Mahlis.

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

[4] A method of delivering an individual's complete nutritional needs via intravenous access.
[5] On 8 April 2024, A/Prof Crosthwaite removed Helen's EndoVAC. Dr Prichard said the perforation was noted to be healed.

Medical cause of death

21. Forensic Pathologist Dr Brian Beer of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 23 April 2024 and provided a written report of his findings dated 26 April 2024. I note that the Mahlis family objected to an autopsy being performed.

22. The post-mortem examination revealed findings consistent with the e-Medical Deposition Form, medical records and Helen's clinical history.

23. Dr Beer provided an opinion that the medical cause of death was 1(a) *Oesophageal perforation following an elective oesophageal dilatation*, secondary to 1(b) *Achalasia*.

24. I accept Dr Beer's opinion.

FAMILY CONCERNS

25. Following Helen's death, her son, Emmanuel Mahlis (**Emmanuel**) submitted concerns regarding the treatment provided to his mother during her admission at Epworth. Emmanuel raised several issues and questions which I will address in turn.

CORONERS PREVENTION UNIT

26. As it was apparent that Helen's death occurred due to a complication of the gastroscopy and oesophageal dilation and that the Mahlis family had concerns regarding the same, I sought the assistance of the CPU to better understand her clinical course and management.[6]

Relevant guidelines regarding oesophageal balloon dilation

27. In his correspondence to the Court, Emmanual referenced international guidelines regarding the performance of oesophageal balloon dilation and questioned: *'Does Australia have similar or same guidelines (to UK Guidelines) that govern the clinical practice of oesophageal dilation?'*

28. The CPU advised that there are two relevant international guidelines:

[6] 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.

a) 2018 UK Guidelines on Oesophageal Dilation in Clinical Practice (which were provided to the Court by Emmanuel) (**UK Guidelines**);[7] and,

b) 2020 American Society for Gastrointestinal Endoscopy (**ASGE Guidelines**) Guidelines on Achalasia.[8]

29. There is no Australian guideline, and, the Epworth did not have its own guideline. In a statement provided by the Director of Medical Services of the Epworth, Dr Jennifer Mines (**Dr Mines**), she wrote:

> *'There is no formal policy, protocol or guideline at Epworth Healthcare which specifically outlines the procedure of Oesophageal Ballon Dilation, nor mandates the use of any international clinical guidelines [. . .]'.*

30. The CPU considered that while the Epworth is at liberty not to mandate a particular international clinical guideline, the community, and professional standards would generally expect healthcare to be provided in accordance with such guidelines if they represent best practice.

<u>Was Helen adequately informed of the risks associated with oesophageal balloon dilation?</u>

31. Emmanuel wrote to the Court:

> *'All my sister [Rosemary] was told is that all procedures carry a risk. Never issues any deeper information about the nature of the benefit or risk of dilation per my mother's situation. Benefit risk ratio. Risk factors were never discussed in detail'.*

32. He also questioned *'why did Dr P Prichard recommend such a high-risk intervention for our mother when past success with Botox had been achieved to treat her intermittent achalasia?'*

33. The CPU referenced the ASGE Guidelines, specifically its comparison of Botox and balloon dilation and conclusion that:

> *There was no significant difference between pneumatic dilation and botulinum toxin arms in clinical success rates within 4 weeks of the initial intervention*

[7] Sami SS, Haboubi HN, Ang Y, et al UK guidelines on oesophageal dilatation in clinical practice Gut 2018;67:1000-1023. Accessible at: https://gut.bmj.com/content/gutjnl/67/6/1000.full.pdf.

[8] Khashab, Mouen A. et al. ASGE guideline on the management of achalasia. Gastrointestinal Endoscopy, Volume 91, Issue 2, 213 - 227.e6. Full text accessible here: https://www.giejournal.org/article/S0016-5107(19)31658-X/fulltext.

[. . .]

There were no adverse events in the botulinum injection arm (total of 151 injection procedures), whereas perforation occurred in 3 cases (total of 188 pneumatic dilation procedures) in the pneumatic dilation arm. These data demonstrate that ***pneumatic dilation is a more effective long-term (>6 months) endoscopic treatment option compared with botulinum toxin injection for patients with achalasia.'*** [9] (emphasis added)

34. In statements provided by Dr Prichard, he described telling Helen and Rosemary that the procedure carried *'a risk of perforation of 5%, and this could be an end [of] life event.'* This is substantiated by contemporaneous notes Dr Prichard recorded which read, *'Discussed the possibility of Rigiflex balloon dilation with a risk of perforation 5%, and this could be an end life event'*. It was also recorded that Rosemary was to discuss the dilation procedure with Michael and the rest of the Mahlis family.

35. Based on a review of the evidence I consider that Dr Prichard outlined the significant risks of the procedure to Helen and Rosemary as her next of kin present during the consultation.[10]

<u>Choice of equipment during the oesophageal balloon dilation</u>

36. Dr Prichard used a *'35 mm Rigiflex Achalasia balloon'*.[11] The CPU pointed to the UK Guidelines which state:

Perform dilatation with pneumatic balloons 30–40 mm in diameter starting at 30 mm in the first session to reduce the risk of complications (GRADE of evidence: high; strength of recommendation: strong).

[. . .]

Perform a second dilatation session 2–28 days later with a larger size balloon of 35 mm (GRADE of evidence: high; strength of recommendation: strong).'[12]

[9] ASGE Guidelines, page 220.
[10] I also note that the Epworth Healthcare Medical Records contains a consent form signed by Helen in which she acknowledged that *'the risks and benefits of receiving/not receiving the treatment have been discussed'.*
[11] *'Rigiflex'* is a brand name.
[12] UK Guidelines, p 1009.

37. When Helen's death was reviewed by Epworth's General Surgery and Gastroenterology Clinical Institute, one of its two *'major concerns'* was regarding *'the size of the balloon used which in an elderly lady was probably too large as a first line dilatation'*.

38. In his statement, Dr Prichard said that a 30 mm balloon *'had been requested a week before the procedure'* but *'there was no stock in the hospital of the smallest Rigiflex balloon (30 mm) on the day of the endoscopic procedure.'* It was Dr Prichard's belief *'that it had been available earlier in the week but had been used for other procedures, such as dilation of bariatric surgery strictures'*.

39. I also sought clarification from the Epworth on the unavailability of the 30 mm balloon. A representative stated 30 mm balloons *'are not commonly used'* and only two units are held at the Epworth Richmond operating theatre. They went on to address the process of ordering *'a specific piece of equipment'* which requires that private clinicians request the apparatus in (i) the theatre booking details or (ii) the patient consent form, with the result that *'the specified equipment is set aside to ensure its availability for the booked procedure'*.

40. The Epworth representative said that neither Helen's theatre booking details nor the patient consent form specified that a 30 mm balloon was required. The two 30 mm balloons usually stored in theatre had been used for prior patients.

41. Regarding whether he contemplated postponing the procedure, Dr Prichard described that *'It had been difficult for the family to have the patient attend hospital. We had been discussing undertaking the dilation for about a year. I thus decided to proceed cautiously with the next size Rigiflex dilator (35 mm).'*

42. The CPU appreciated that Dr Prichard was required to weigh the risks and benefits of proceeding *'cautiously'* with a larger balloon (which it understood to mean not inflating it to the full 35 mm) or cancelling the procedure and the CPU considered the decision to continue was reasonable in the circumstances.

43. However, the CPU also identified that further clarity may be indicated regarding ordering *'specified equipment'* for surgical procedures. I will address this in my finding.

<u>Choice and timing of post operative investigations</u>

44. Emmanuel expressed concerns that the perforation was not sooner identified. He pointed to the UK Guidelines and contended:

'The delay in our mother receiving a follow up contrast media CT scan immediately after her procedure and the lack of concern or urgency to establish the presence of a perforation when our mother expressed chest pain [. . .]'.

45. Emmanual pointed to the *'false negative x-ray'* of 25 March 2024 (the barium swallow test) as the basis for Dr Prichard's decision to recommence feeding. He hypothesised that had Dr Prichard performed a contrast media CT within 24 hours of the operation then Helen *'would have had a better chance of survival'*.

46. The CPU documented that three different radiological examinations were performed to diagnose Helen's oesophageal perforation:

    a) A chest x-ray on 22 March 2024 after the procedure,

    b) A barium (contrast) swallow test with x-ray on 25 March 2024; and,

    c) A CT scan on 26 March 2024.[13]

47. Dr Mines explained:

    'Choice of diagnostic imaging modality is made on a case-by-case basis, by the treating specialist, in consultation with the radiology department, based on clinical indications. is not routine at Epworth for patients undergoing balloon dilatation of their oesophagus to undergo contrast CT examination immediately post-procedure. Dr Prichard ordered a plain chest X-ray in his routine post-operative orders following the procedure prior to commencing soft diet.'

48. The CPU agreed that the method of post-operative investigation should be informed by the clinical scenario and emphasised that these decisions ought to also be informed by guidelines and best practice, where possible.

49. The UK Guidelines states that post-operative investigations are not always required:

    'Consider performing a water-soluble contrast swallow after dilatation to screen for perforation, but it is not essential'[14]

[13] The CPU noted that the CT was initially and erroneously performed with intravenous contrast, and then a subsequent CT was performed with oral contrast.
[14] UK Guidelines, p 1010.

50. It is only when a perforation is suspected that the UK Guideline recommends that a contrast CT be performed:

> *'Suspect perforation when patients develop pain, breathlessness, fever or tachycardia. Transient chest pain is not uncommon following dilatation but persistent pain should prompt a CT scan with oral contrast to look for perforation.'*[15]

51. Dr Prichard ordered an x-ray following the procedure and barium swallow test on 25 March 2024 when he became suspicious that there was a perforation. The UK Guidelines warn practitioners that such studies are not conclusive regarding the presence of a perforation:

> *'A chest X-ray examination may show pneumothorax, pneumomediastinum, air under the diaphragm or a pleural effusion but* ***normal appearances do not exclude perforation.*** *If clinical suspicion is high or if endoscopy examination raises the possibility of a deeper laceration than just mucosal, then* ***ideally a CT scan with oral contrast should be performed. Conventional contrast studies are less sensitive and may miss small perforations.*** *Moreover, CT can detect other complications, such as pleural effusions, pneumopericardium and pneumoperitoneum'*[16] (emphasis added)

52. I note that Dr Prichard had consulted with a radiologist when making his decision to perform a barium swallow test:

> *'If a perforation is suspected a radiological contrast study is the next step. Which type of contrast study was discussed with the experienced consultant radiologist on duty; who thought that a gastrografin/barium swallow rather than a CT scan with contrast was the best initial investigation.'*

53. Regarding the timing of the contrast CT, which Emmanuel contended ought to have occurred earlier, the CPU explained that according to the UK Guideline, when a perforation is suspected, a contrast CT should be performed as an emergency.[17]

[15] UK Guidelines, p 1009.
[16] Ibid.
[17] UK Guidelines, p 1010 fig 1.

54. Dr Prichard stated that the x-ray performed on 22 March 2024 was in response to his identification of a mucosal tear during the procedure. He explained that his suspicion levels were *'not high'* and that the x-ray was *'precautionary'*.[18]

55. Dr Prichard's concern escalated over the ensuing days due to Helen's declining condition, prompting him to seek a radiologist's advice on the morning of 25 March 2024. The CPU considered that the performance of a contrast CT, and probable diagnosis of the oesophageal perforation, was delayed from when Dr Prichard's concerns first arose on 25 March 2024 and when the CT scan was performed the following day. The CPU did acknowledge that some of the delay could be attributed in part to seeking radiological advice.

Was Dr Prichard aware of relevant international guidelines?

56. Dr Prichard was not aware of the current UK Guideline at the time of Helen's death. He explained that he was aware of its 2004 predecessor, *'Guidelines on the use of oesophageal dilation in clinical practice'*, and of the ASGE Guideline.

57. He provided his opinion that *'the ASGE 2020 guideline is more detailed regarding the management of Achalasia than the 2018 UK guideline. These state that the conventional approach is graduated dilation starting at 30 mm. This was not, however, presented as a recommendation. It was acknowledged that "Most included studies did not clarify whether the reported clinical success was achieved after a single dilation or with graded dilations".'*

58. The CPU acknowledged that the UK and ASGE Guidelines may not reference the details of the studies relied upon to make recommendations and that there may be clinical subtleties that influence the choice of procedure and outcome in a particular patient. However, the CPU considered the Guidelines were a solid foundation for clinicians assessing the available information evidence for their clinical recommendations.

59. The CPU also considered the Medical Board of Australia's code of conduct: *'Good medical practice: a code of conduct for doctors in Australia'* which makes a number of recommendations to practitioners, including:

[18] I note that in Dr Prichard's statement of 26 May 2025, he provided a slightly different recollection: '*a perforation was not suspected at the time of the endoscopic procedure or afterwards in the recovery'.* In his final correspondence to the Court, dated 17 April 2026, he confirmed his original position (of 20 July 2024) and stated *'I ordered the chest x-ray to check for a gross perforation given the mucosal tear identified, before commencing Ms Mahlis on a soft diet. My suspicion level for a gross perforation was not high given the findings of my inspection. My ordering of a chest x-ray at this time was precautionary.'*

a) Ensuring they have adequate knowledge and skills to provide safe clinical care,

b) Providing treatment options based on the best available information,

c) Making responsible and effective use of the resources available; and,

d) Keeping their knowledge and skills up to date.

CLINICAL REVIEW INTISTUTE AND ACTIONS TAKEN BY EPWORTH HEALTHCARE FOLLOWING HELEN'S DEATH

60. On 23 April 2024, a preliminary incident assessment meeting (huddle) was attended by relevant members of Epworth's medical, nursing, quality and executive teams. They determined that the care provided did not warrant an internal review.

61. The matter was referred to Epworth's General Surgery and Gastroenterology Clinical Institute (**Clinical Institute**) as mentioned above.[19] Following its review, the Clinical Institute made the following comments, amongst others:

a) That the oesophageal perforation was due to the balloon being too large, particularly given Helen's advanced age and frailty,

b) There was a delay in recognising the perforation *'as evidenced by the fact that the patient was not referred for 4 days where the clinical diagnosis was very likely to be a perforation at the earliest change'*

c) Early recognition and diagnosis of the oesophageal perforation as particularly important given Helen's advanced age and frailty; and,

d) A CT with oral contrast was a more appropriate post-operative radiological option to *'provide additional information and pick up on smaller leaks'*.

62. As to the question of whether earlier diagnosis of the perforation would have changed Helen's outcome, the Clinical Institute could not be certain. It stated that due to Helen's *'deconditioned'* state she was unlikely to survive.

[19] The Clinical Institute brings together the practitioners across Epworth's hospitals relating to a specific disease or organ system, for education, quality and process improvement, research, audit, and training of medical students. The Clinical Institute is also committed to advancing patient safety and quality of care through providing expert, peer review of clinical incidents and patient outcomes.

63. The Clinical Institute concluded:

> *'The major concern about the management of this patient relates to the size of the balloon used which in an elderly lady was probably too large as a first line dilatation and secondly the significant delay in the recognition of a likely perforation in an elderly lady. This resulted in delayed investigations for diagnosis and also the delay in commencement of treatment. It may be that this would have had no impact on the final outcome given the age and frailty of the patient.*
>
> *[. . .]*
>
> *This patient will also be presented at the major morbidity mortality audit which will provide further feedback from a wider group.'*

64. The major morbidity mortality audit considered Helen's death and did not make any recommendations.

CONCLUSION OF THE CPU

65. The CPU agreed with the Clinical Institute Review that the delay in diagnosis may not have altered the outcome given general prognosis of oesophageal perforation, especially in patients with the age, frailty, and co-morbidities of Helen.

NATURAL JUSTICE

66. In advance of finalising my investigation, the Court advised Dr Prichard of the conclusions which I was intending to make and provided him with an opportunity to respond. On 17 April 2026, Dr Prichard provided his response, some of which has been incorporated into this finding. He also provided additional information as follows.

<u>Ordering special equipment</u>

67. Dr Prichard explained his usual ordering process for specialised surgical items. He stated that it is his *'usual practice'* to request a specific size of balloon when booking patients at the Epworth. This request is generally communicated via email or telephone to the Group Manager Prothesis and Loans of the Epworth. He provided the Court with copies of email correspondence between Dr Prichard's office and the Epworth ordering a size 30 balloon for planned procedures on 1 July, 29 August and 31 October 2023 (these dates were ultimately cancelled).

68. Dr Prichard stated he was unable to identify an email to the Epworth requesting the balloon be ordered for the operation on 22 March 2024. He explained that he does sometimes order the equipment himself via telephone but could not recall if he did so on this occasion. He explained that he believes, *'based on usual practice, that the order would have been placed via telephone in the week prior to the procedure'.*

69. Had he known that the smaller balloon would not have been available, Dr Prichard stated he would not have booked the surgery for 22 March 2024. It was his expectation when he went to the operating theatre that morning that the balloon would be available.

Delay in organising a CT

70. Dr Prichard addressed the evidence that the delay in ordering a CT scan may have resulted in a delay to diagnose Helen's perforation. He acknowledged the 2018 UK Guidelines which state that a CT scan is to be performed when a perforation is first suspected and clarified that he only *'suspected'* that a perforation was present after Helen declined on or around 25 March 2024.

71. Dr Prichard was guided by the radiologist's opinion and acknowledged that his own view at the time was *'that the barium swallow/CT scan modalities were relatively similar in terms of their ability to detect a perforation'*. He opined that even if a CT had been performed at the same time as the barium swallow test, that it may not have identified a perforation.

72. Having considered the CPU's conclusion, Dr Prichard agree that Helen *'was of advanced age, frail and had multiple comorbidities and that even if the oesophageal perforation had been identified and treated earlier, it is unfortunately unlikely to have changed the outcome'.*

Guidelines in force at the time of Helen's death

73. Dr Prichard acknowledged that he was not aware of the 2018 UK Guidelines at the time. He also acknowledged that they appeared as part of the journal, *Gut,*[20] which he reviews as part of his Continuing Professional Development requirements. He stated, *'I can only assume that unfortunately, I did not review that particular release of Gut in 2018'.*

[20] *Gut 'is a leading international journal in gastroenterology and hepatology'* and is an official journal of the British Society of Gastroenterology. BMJ Journals *Gut*, accessible at: https://gut.bmj.com/.

FINDINGS AND CONCLUSION

74. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[21] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Helen Mahlis, born 12 July 1936;

    b) the death occurred on 22 April 2024 at Epworth Richmond, 89 Bridge Road, Richmond Victoria 3121, from 1(a) *Oesophageal perforation following an elective oesophageal dilatation* secondary to 1(b) *Achalasia*; and,

    c) the death occurred in the circumstances described above.

76. The evidence supports a finding that Helen's death was the result of two compounding factors (i) the use of a balloon that was an inappropriate size for a first-time dilation in a patient of Helen's advanced age and frailty and (ii) a potential delay in the diagnosis and treatment of her oesophageal perforation.

77. I find that Helen appropriately consented to the procedure and medical records indicate that she was advised of the possibility of an oesophageal perforation and that the same could be fatal.

[21] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

78. I accept Dr Prichard's evidence that when he identified the mucosal tear on 22 March 2024, the x-ray was ordered as a precaution and not because he was materially suspicious that a perforation had occurred. Following Helen's deterioration, I find that a CT scan with oral contrast should have been ordered instead of a barium swallow test to reflect gold-standard care in keeping with relevant guidelines. Based on the evidence before me however, I cannot definitively conclude that a CT scan performed at this time would have identified the perforation.

79. The evidence is sufficiently cogent to support a finding that Dr Prichard did not avail himself of relevant recommendations of the UK Guidelines that were available at the time.

80. I note that Helen was of an advanced age, she was frail and had multiple comorbidities. Even if the oesophageal perforation had been identified and treated in a timely manner following the procedure, I cannot be certain that it would have changed her outcome. It would have however, provided an opportunity for earlier treatment and more comfortable care.

COMMENTS

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

81. Dr Prichard was not aware of the 2018 UK Guidelines at the time of Helen's procedure and death – I find this troubling. While I acknowledge that Dr Prichard deferred to radiologists regarding what post operative investigations would be most appropriate, it is apparent that the radiologist was similarly unaware that an emergency contrast CT was indicated in such circumstances.

82. Neither nationally, through the Royal Australian College of Physicians nor locally was there a specific guideline(s) for achalasia management or best clinical practice when performing oesophageal balloon dilation. Dr Prichard ought to have kept himself informed on current international standards and incorporated these into his practice. It is apparent that he made an effort to do so and was aware of the ASGE Guidelines and the former UK guideline of 2004, however, he was not aware of the 2018 UK Guideline as would be reasonably expected of him.

83. In this context, the Code of Conduct requires that practitioners ensure they have adequate knowledge and skills to provide safe clinical care, provide treatment based on the best available information, make responsible and effective use of available resources and keep their knowledge and skills up to date, which I consider would include international guidelines.

84. I will direct this finding is distributed to the Medical Board of Australia and the Australian Health Practitioners Regulation Agency as they are best placed to consider the conduct of medical practitioners in the context of their ethical and professional obligations regarding ongoing education.

RECOMMENDATIONS

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

i) I recommend that **Epworth Healthcare** consider increasing the stock of 30 mm Rigiflex balloons available to practitioners at the Epworth Richmond operating theatre(s); and

ii) I recommend that **Epworth Healthcare** review its policy on ordering special equipment ahead of a procedure to ensure there is clarity for practitioners as to what specific equipment must be requested and how it must be requested, with the view that future shortages of required equipment can be avoided.

I convey my sincere condolences to Helen's family for their loss and thank them for their participation in the coronial process.

Pursuant to section 73(1A) 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:

Michael Mahlis, Senior Next of Kin

Dr Peter Prichard, c/- Meridian Lawyers

Epworth Healthcare

Medical Board of Australia

Australian Health Practitioner Regulation Agency

Senior Constable Maddison Young, Reporting Member, Victoria Police

Signature:

Coroner Leveasque Peterson

Date: 12 June 2026

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.