IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 2701

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Callie Griffiths-I'Anson
Delivered on:	31 March 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest: 6, 7 and 8 October 2021 Final Submissions: November 2021
Findings of:	Coroner Paresa Antoniadis Spanos
Counsel assisting the Coroner:	Leading Senior Constable James Kett from the Police Coronial Support Unit
Representation:	Ms S. Gold of Counsel appeared on behalf of Callie's parents Natalia and Thomas Griffiths-I'Anson instructed by Polaris Lawyers. Mr R. Harper of Counsel appeared on behalf of the Royal Children's Hospital instructed by K & L Gates Lawyers.

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INTRODUCTION

1. Callie Griffiths-I'Anson who will be referred to as Callie in this finding was the much-loved daughter of Natalia and Thomas Griffiths-I'Anson and younger sister of Denika and Lexia. Callie was born on 15 October 2015 and was just two years and three months of age when she died at Corowa Hospital, New South Wales, on 12 January 2018.

2. The Griffiths-I'Anson family moved from The Rocks in Sydney to Oaklands, New South Wales, in September 2017. Callie's father gained employment with a local farmer while her mother worked on a casual basis at the local Oaklands Hotel. Prior to the incident which set in train the series of events that led to her death, Callie had no known medical conditions apart from allergies to nuts and a sensitivity to dairy products. She was otherwise a healthy, active child albeit one with a small build.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

3. On Monday 11 December 2017, Callie was at the Oaklands Hotel with her sister Lexia while their mother stepped out to arrange payment of some bills at the Australia Post Office nearby. Ms Griffiths-I'Anson left the girls in the care of colleagues at the hotel while they played in the hotel courtyard. Without apparently attracting the attention of a responsible adult, Callie came inside and entered the front bar area where she gained access to and ingested a caustic alkali liquid used to clean drinking glasses.

4. A staff member who was present immediately assisted Callie by flushing out her mouth with water while the publican went to alert Ms Griffiths-I'Anson. Once Callie's mother returned to the hotel, she tried to contact the Poisons Hotline without success. Although not appearing distressed initially, Callie's lips started bleeding and she started having trouble breathing. The publican called emergency services and Ms Griffiths-I'Anson contacted her husband who attended the hotel a short time later.

5. Berrigan paramedics responded, arriving at the hotel at around 3.30pm. They took Callie to Corowa District Hospital where she was initially assessed for caustic injuries, primarily to her oesophagus. Callie was then taken to Albury Base Hospital for initial treatment of her injuries before being air-lifted to the Royal Children's Hospital, Melbourne (**RCH**)

6. The clinical management and care provided to Callie at the RCH in the aftermath of her caustic injuries, in particular, during and immediately following a scheduled review at the RCH on 11

January 2018 was the primary focus of the coronial investigation and will be discussed in some detail below.

7. Suffice for present purposes to say that the Griffiths-I'Anson family returned to their home in Oaklands on the afternoon/evening of 11 January 2018 after attending the RCH for a scheduled review of Callie's injuries. After a somewhat disturbed evening and night, Callie's parents woke at about 6.00am on the morning of 12 January 2018 to the sounds of Callie making a gurgling sound. When they tried to sit her up, Callie was limp and appeared to stop breathing. Ms Griffiths-I'Anson called 000 while Callie's grandmother commenced cardiopulmonary resuscitation (**CPR**).

8. Upon their arrival, paramedics continued CPR, intubated Callie and transported her to Corowa District Hospital where clinical staff continued CPR. Unfortunately, Callie could not be revived and was pronounced deceased at 7.55am on 12 January 2018.

9. Callie's death was reported to the New South Wales State Coroner and the initial investigation of her death occurred in that State.

10. Having conducted a preliminary consideration of the circumstances and in accordance with established practice, by letter dated 2 May 2018, the NSW State Coroner formally referred Callie's death to the Victorian State Coroner for investigation of the clinical management and care provided to Callie at RCH, Melbourne, which seemed to be the main issue requiring investigation, and made the Coroners Court of Victoria the more convenient forum. Another reason for the referral was the concern identified by the NSW State Coroner that any recommendation made by an NSW Coroner in relation to Callie's death would be unable to be directed to a Victorian entity.

11. By letter dated 13 June 2018, Callie's parents were advised by the Registry Manager, Coroners Court of Victoria, that the referral had been accepted by the Victorian State Coroner and had been allocated to me for investigation.

INVESTIGATION AND SOURCES OF EVIDENCE

12. This finding is based on the totality of the material the product of the coronial investigation of and inquest into Callie's death. That is, the initial brief of evidence compiled by New South Wales police which includes relevant witness statements, the forensic pathologist's report and medical records, as reconfigured by Leading Senior Constable James Kett from the (Victorian)

Police Coronial Support Unit who assisted me in this investigation and inquest;[1] the evidence of the witnesses required to testify at inquest and any documents tendered through them; and the final submissions of Counsel.

13. All of this material, together with the inquest transcript, will remain on the coronial file.[2] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

14. The purpose of a coronial investigation of a *reportable death*[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4] Callie's death clearly falls within the definition of a reportable death in section 4 of the Act, satisfying both section 4(2)(a) of the Act which includes (relevantly) a death that appears to have resulted, directly or indirectly, from an accident and section 4(2)(b)(ii) which captures deaths following a medical procedure where the procedure is or may be causally related to the death.

15. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[5]

[1] The compilation of material will be referred to as the "inquest brief" in the rest of this finding.
[2] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.
[3] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.
[4] Section 67(1).
[5] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

16. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[6]

17. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[7] These are effectively the vehicles by which the coroner's prevention role can be advanced.[8]

18. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[9]

IDENTITY

19. Callie Griffiths-I'Anson, born 15 October 2015, aged two years and two months, was identified by her father Thomas Griffiths-I'Anson who signed an Identification Statement to this effect before Senior Constable Matthew Smith (Registered No 38916) of the New South Wales Police.

20. Callie's identity was not in issue and required no further investigation.

CAUSE OF DEATH

21. Callie's body was taken to the Department of Forensic Medicine, Newcastle, New South Wales, where a paediatric autopsy was performed by Dr Allan Cala, Senior Staff Specialist in Forensic Pathology on 22 January 2018. Dr Cala's eight-page autopsy report is included in the inquest brief and details his understanding of the circumstances as reported by the police to the coroner, his findings at autopsy and his opinion about the medical cause of Callie's death.[10]

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[6] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[7] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[8] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[9] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

[10] Pages 1-8 of the inquest brief.

22. Dr Cala noted that imaging in the form of post-mortem CT scanning showed (1) bilateral pleural effusions and (2) free fluid in abdominal cavity[11]. He summarised his autopsy findings as (1) copious dark brown liquid in abdominal cavity and (2) perforation of distal oesophagus.[12] Apart from these findings, there was no evidence of natural disease or injury of a type that may have caused or contributed to Callie's death.[13]

23. The following comments were made by Dr Cala expanding on his autopsy findings and are produced verbatim due to their forensic significance –

> *"1. Autopsy examination showed approximately 100mL dark brown fluid throughout the abdominal cavity. This fluid appeared to have originated from an iatrogenic (medical) perforation of the distal oesophagus. There was an abnormal communication from the distal oesophagus into the abdomen adjacent to the normal oesophagus. It was effectively, a "hole" through which the feeding tube had passed, allowing feeding fluid to directly pass into and accumulate in the abdominal cavity.*
>
> *2. The feeding tube had been removed prior to autopsy by mortuary staff so its actual position at the time of death is unknown. It is strongly suspected however this tube may have perforated the oesophagus at a time when the oesophageal surface was weakened as a result of chemical inflammation. The tube has presumably perforated the oesophagus at the time of insertion and become inadvertently positions in the upper abdomen. The treating doctors appear to have been unaware of this."*[14]

24. I note that Dr Cala provided further detail of the findings pertaining to the peritoneal cavity and the distal oesophagus under the heading "alimentary track" and that his microscopic examination of oesophageal tissue had the appearance of an abnormally and recently formed false track, that is one that was formed within 24 hours of death.[15]

25. Dr Cala's report also contained the results of post-mortem toxicological analysis which detected alcohol at a level of 0.03g/100mL, in keeping with the formation of decompositional gases, and

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[11] Page 8 of the inquest brief.
[12] Page 3 of the inquest brief.
[13] Pages 5-7 of the inquest brief.
[14] Page 3 of the inquest brief. I note that an even more detailed description of the findings pertaining to the peritoneal cavity and distal oesophagus appear under the heading "alimentary tract" at page 6 of the inquest brief. This aspect will be discussed below as it pertains to the primary focus of the coronial investigation – see paragraph 32 and following below.
[15] Page 7 of the inquest brief. The full excerpt is *"Sections show mucosal ulceration and marked acute inflammation in all layers of the oesophagus. There is a false track adjacent to the oesophagus which is surrounded by haemorrhage (blood), with a dense acute inflammatory cell infiltrate forming a cuff around the lumen of the track. The appearances are of an abnormally and recently formed (within 24 hours of death) false track."*

paracetamol at 9.4mg/L, in keeping with normal therapeutic use, but no other commonly encountered drugs or poisons.[16]

26. Dr Cala concluded that the cause of Callie's death was *1(a) perforated oesophagus (secondary to) 1(b) complications of treatment of oesophageal injuries (following) 1(c) caustic soda ingestion.*

27. I accept Dr Cala's opinion as to the cause of Callie's death.

THE FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

28. As indicated at the directions hearing, the focus of the coronial investigation of Callie's death was not on how she came to ingest the caustic dishwashing liquid. Issues such as her supervision at the hotel after her mother left, the storage of the dishwashing liquid, the apparent ease with which she accessed and ingested the liquid and first aid attempts at the scene would not be examined. I took the view that it was self-evident that Callie was not adequately supervised, that the hotel was not a safe place for a child of her age to be left to wander, and as children of that age are wont to do, she ingested the liquid accidentally.[17]

29. According to the circumstances as reported by the police, there was no suggestion of inadequacy in the clinical management and care provided to Callie during the acute phase of her injury, that is first at Corowa, then at Albury Hospitals or during the process of air-lifting her to the Royal Children's Hospital, Melbourne (**RCH**).

30. While aspects of Callie's clinical management and care during her first admission to the RCH, from 12 December 2017 until her discharge home with her parents on 5 January 2018, were relevant and touched on during the inquest, the family raised no particular concerns about Callie's first admission.

31. Rather Thomas and Natalia's focus and the primary focus of the inquest was on the clinical management and care provided to Callie during and immediately following a scheduled oesophagoscopy and oesophageal dilation procedure at the RCH on 11 January 2018. It is convenient to address the relevant evidence under the following headings:

    a. When and how the iatrogenic injury occurred.

    b. Anaesthetic management.

[16] Page 7 of the inquest brief.
[17] See the statement of Dean Edmunds, one of the owner/licensees of the Oaklands Hotel, dated 22 February 2018 at page 45 of the inquest brief.

c. Callie's post-operative recovery.

d. The discharge plan.

e. Callie's parents seek advice from RCH after discharge.

When and how the iatrogenic injury occurred

32. While Dr Cala's formulation of the cause of death makes a clear causal connection between the procedure undertaken at the RCH on 11 January 2018 and Callie's death resulting from a perforation of the oesophagus, his comments about the precise time of the perforation or the precise aspect of the procedure which caused the perforation (or mechanism of injury) were speculative as the nasogastric feeding tube had been removed by mortuary staff prior to his examination and autopsy.[18]

33. Both in his statement and at inquest, Dr Crameri explained the need for the procedure Callie underwent on 11 January 2018 and previously; the steps involved in the procedure; and the issues encountered during the procedure on 11 January 2018.[19]

34. According to Dr Crameri, part of the RCH's routine management for caustic injuries is the performance of serial rigid oesophagoscopies to assess the oesophagus at regular intervals and to gently dilate the oesophagus to try and avoid significant stricturing and scarring through the early healing phase.[20] Callie underwent the first such procedure at Albury Hospital within hours of her ingestion of the caustic alkali substance. Two further procedures were performed by Dr Crameri while Callie was an inpatient at the RCH between 12 December 2017 and 5 January 2018. The procedure on 11 January 2018 was the third procedure performed by Dr Crameri and the fourth overall that Callie underwent.[21]

35. Dr Crameri's evidence was that the procedure is performed under anaesthetic and involves several steps. Firstly, an oesophagoscopy is performed with a rigid metal scope to enable visualisation of the oesophagus. On 11 January 2018, this step only allowed visualisation of 'the very upper oesophagus' which was as far as one could see. To go further would have been unsafe and would not accord with standard practice. The second step is dilatation of the oesophagus which involves

[18] See paragraph 23 above and Dr Cala's autopsy report at page 3 of the inquest brief.
[19] Dr Crameri's ten-page statement dated 18 September 2018 commences at page 9 of the inquest brief and his evidence commences at transcript page 133.
[20] Dr Crameri's statement at pages 11-12 of the inquest brief.
[21] Transcript page 135, 140. Note too Dr Crameri's evidence at transcript page 138 *"In the management of these conditions there is the initial monitoring until we get healing of the area and assessment of scar tissue, and then there is the management of scar tissue which requires ongoing dilatation, that is likely to last for her lifetime, but certainly through her childhood."*

passing a series of tubes down the oesophagus to assess its diameter and to identify any strictures of the muscle layer. Finally, Callie's nasogastric feeding tube (**NGT**), which had been removed prior to the procedure to facilitate access, was re-inserted so she could continue to receive nutrition without further aggravation of her oesophagus.[22]

36. As far as could be seen during the procedure on 11 January 2018, Callie's oesophagus still had a significant amount of contact bleeding without evidence of significant healing. Although not sufficiently outside the routine to be "really abnormal", Dr Crameri's evidence was that he would have expected to see more healing by that stage, almost five weeks after the initial injury. Yet, the tissue still seemed quite inflamed and fragile which he felt likely reflected the severity of the initial injury.[23]

37. Another aspect of the procedure conducted on 11 January 2018 was that there was some difficulty replacing Callie's NGT at the end of the procedure.[24] At inquest, Dr Crameri gave an expanded description of this difficulty and how it was resolved. The difficulty was encountered on Dr Crameri's initial attempt to reinsert the NGT removed prior to the procedure, known to be an appropriate length for Callie. He described feeling some resistance such that he was not prepared to apply more pressure to overcome as he did not consider it safe to do so.[25] As the NGT was 'very soft, very flexible and prone to coiling', Dr Crameri then tried using a flexible guide wire which had been used during dilatation. However, he found that the NGT was still "catching at the lower end of the oesophagus". Finally, a new NGT was brought to theatre which had a pre-existing metal stylet with a little more rigidity enabling it to be more easily directed and placed within the stomach and its correct placement confirmed by imaging.[26]

38. In Dr Crameri's opinion, the most likely time the false tract was created was during the dilatation phase of the procedure when the oesophagus was under the greatest strain and that the perforation of the oesophagus occurred later, that it possibly 'broke down later, especially if she had some vomiting'. However, Dr Crameri also allowed of the possibility that the perforation could have resulted from his attempts to reinsert the NGT.[27]

[22] Transcript page 141-142.
[23] Dr Crameri's statement at pages 9 and 12 and transcript page 140 and following.
[24] Ibid.
[25] This is my paraphrase of my understanding of his evidence in this regard at transcript pages 142, 195-198.
[26] Transcript pages 142-146.
[27] Transcript pages 161-162,

39. Dr Christopher Kirby is a consultant paediatric surgeon engaged by the court to provide an independent expert report.[28] In his report, Dr Kirby characterised the procedure as described in the operation record as "best practice technique." After the initial difficulty encountered in replacing the NGT, Dr Kirby considered the subsequent efforts made by the surgical team to replace the NGT, as described by Dr Crameri, to be reasonable.[29] Once it was clarified at inquest that Dr Crameri's description of the guidewire "coiling above the gastro-oesophageal junction" was visualised in real time using fluoroscopy and not simply presumed, Dr Kirby found that very reassuring.[30]

40. Dr Kirby's evidence about the likely time or stage in the procedure that the false tract was created in Callie's oesophagus differed slightly from Dr Crameri's. Dr Kirby favoured the hypothesis that the false tract, including perforation of the oesophagus, was created by instrumentation during the procedure, rather than after the procedure as suggested by Dr Crameri. However, Dr Kirby allowed of the possibility that an incomplete full thickness tract was created in the operating theatre and subsequently perforated the oesophagus leading to the peritoneal cavity in the hours after and described the difference in their opinions on this issue as "splitting hairs".[31]

41. As there is no suggestion that the perforation was caused by some other mechanism independent of the procedure, the forensic significance of this hair splitting is the distinction between a direct or indirect cause of the perforation that led to Callie's death.[32]

42. Relevantly, there is nothing in Dr Kirby's report or his evidence at inquest to suggest that the iatrogenic injury that led to Callie's death should have been detected or suspected by Dr Crameri or any other RCH clinical staff intraoperatively, post-operatively or at any time before her discharge home with her parents.

Anaesthetic Management

43. On my understanding of the evidence, there is no suggestion that anaesthetic management of Callie's procedure, caused or contributed to her death. Rather, the family have raised concerns

[28] Dr Kirby's report dated 22 May 2020 including a brief curriculum is at pages 61-63 of the inquest brief. Dr Kirby has worked as a consultant paediatric surgeon at the Women's & Children's Hospital, North Adelaide, continuously since 2001 and Head of Paediatric Surgery and Thoracic Surgery as at the date of his report and the inquest.
[29] Dr Kirby's statement at pages 61-62 of the inquest brief.
[30] Transcript page 355.
[31] Transcript pages 357-358.
[32] Transcript page 358.

about Callie's recovery from the procedure and question the choice (and dosage) of anaesthetic in circumstances where they feel she did not recover as well as she had from previous procedures.[33]

44. Mr Griffiths-I'Anson's evidence was that he and his wife told the anaesthetist[34] Callie did not like the anaesthetic mask and asked if there was an alternative. He understood that the anaesthetic would be administered intravenously, and no mask would be required. He saw the pre-medication given intravenously and was concerned that it made Callie very restless and anxious. Having accompanied Callie into theatre, he saw her go to sleep immediately as the mask was applied whereas in the past she had cried or struggled before eventually falling asleep. He heard the anaesthetist say that he had given her a dose for a two-year-old and was concerned as Callie was much smaller than the average two-year-old. Mr Griffiths-I'Anson noted the procedure took longer than before and, in recovery, Callie was under a heated blanket as her temperature had dropped and was still low. She looked dazed and restless, was writhing in bed and did not look like she had completely woken up.[35]

45. Ms Griffiths-I'Anson's concerns about Callie's anaesthetic on this occasion were broadly consistent with her husband's, except that she was not present in theatre and her statement contains a hearsay account of her husband's observations in theatre.[36]

46. Anaesthetist Dr Robert McDougall is a specialist paediatric anaesthetist routinely involved in paediatric oesophageal dilatation procedures and the anaesthetist who managed Callie's anaesthesia on 11 January 2018.[37] Dr McDougall was not involved in Callie's previous procedures and first saw her at 7.30am on 11 January 2018 for a pre-anaesthetic review. Callie was a little unsettled which he did not find unusual and prescribed midazolam (0.5mg per kilo being 4.25mg

[33] Statement of Natalia Griffiths-I'Anson dated 8 February 2018 is at pages 29-36 of the inquest brief – see paragraph 10 at pages 32-33 where Natalia is concerned that the anaesthetic dose given to Callie was for a two-year-old and she was under-weight for a two-year-old; that she was not grizzly and agitated this time but very sleepy; and that she was cold and required heating. In Natalia's second statement dated 24 September 2021 at pages 36.1-36.4 of the inquest brief her evidence pertaining to anaesthetic-related issues is at paragraphs 2-7 on page 360.1. Thomas Griffiths-I'Anson's statement dated 31 July 2000 is at page 37-40 of the inquest brief. His concerns relating to the use of a mask and the effects of the pre-medication given to Callie are at paragraphs 6-9 at page 37 of the inquest brief.

[34] I note that in his statement at page 37 of the inquest brief, Mr Griffiths-I'Anson refers to speaking to a person he believed to be a doctor, not the anaesthetist as such, but as there is no suggestion that it was someone else, it is reasonable to infer that he was referring to Dr McDougall.

[35] Transcript pages 87-88, 93-95.

[36] See Mrs Griffiths-I'Anson's first statement at paragraph 10 on pages 32-33 and her second statement at paragraphs 2-7 on page 36.1 and paragraph 18 on page 36.2 respectively of the inquest brief. Transcript pages 22-23, 29, 31-32, 47-48, 57-58, 81,

[37] Dr McDougall's statement dated August 2020 is at pages 55-56 of the inquest brief and includes brief details of his formal qualifications and experience.

in total) as a pre-medication to help calm Callie prior to administration of the general anaesthetic. This was given by a nurse at about 7.45am.[38]

47. The primary medications used for Callie's general anaesthetic were sevoflurane administered via inhalation and fentanyl administered intravenously. Other medications were administered as documented, including propofol, atracrurium and dexamethasone. Dr McDougall could not recall saying he had dosed Callie 'as a two-year-old' and doubted that he would have 'framed a response in this way'. He testified that the dose of each medication was calculated in accordance with Callie's weight, except that the inhalational anaesthetics given to maintain anaesthesia were given according to a percentage of inhaled gas and not the patient's weight. Callie's anaesthesia was commenced at 0834 hours and concluded at 0958 hours. According to Dr McDougall, there were no anaesthetic complications during the procedure.[39]

48. At inquest, Dr McDougall was taken to the records of Callie's progress in Stage 1 Recovery and Stage 2 Recovery. He was of the view that her progress in terms of recovery from the effects of anaesthesia, as reflected in her vital signs and other observations, was as would be expected.[40] Having reflected on the tragic outcome in Callie's case, Dr McDougall could not identify anything he would do differently in the future.[41]

49. Dr McDougall addressed the parents' concerns about Callie's anaesthetic both in his statement and at inquest. He testified that while Callie had not been given a pre-medication for previous procedure, he prescribed midazolam on this occasion as a pre-medication for its anxiolytic, sedative and amnesic properties. Midazolam also disinhibits various neural pathways so a patient can appear disinhibited or restless while still benefitting from its anxiolytic properties. While Dr McDougall was not prepared to attribute anxiety to the administration of midazolam, he agreed that 'restlessness would be quite a good description of its effect' in some patients.[42]

50. Dr McDougall did not recall a conversation with the parents about Callie's discomfort with the mask but thought he must have taken this into account when deciding to give a pre-medication. He testified that it is impossible to guarantee that a mask would not be required at all and confirmed that Callie's anaesthetic involved both a mask and an intravenous line. Among other things, a mask afforded better control of the patient's airway. In a distressed child, his inclination would

[38] Dr McDougall's statement at page 55 of the inquest brief.
[39] Ibid and transcript page 240-241 and page 261 where Dr McDougall describes how the dose he prescribes (in the case of midazolam 0.5mg per kilo) is electronically calculated, then prepared and administered by nursing staff.
[40] Transcript pages 253-259.
[41] Transcript page 249.
[42] Transcript pages 239-240.

be to use a pre-medication to assist in the induction of anaesthesia as smoothly and quickly as possible.[43]

51. According to Dr McDougall, body temperature is not routinely monitored during this particular procedure as there is a lack of room to insert a temperature probe. He agreed that at 34.3 degrees Celsius, Callie's initial temperature in recovery was low. However, his view was that this is to be expected in a patient who has been anaesthetised for an hour and a half. With time in recovery and warming blankets and as the anaesthetic wears off, the body's ability to control its temperature is restored and the temperature normalises as occurred in Callie's case.[44]

52. In terms of the parents' concern that Callie was sleepy, groggy, still out of it or just not herself, Dr McDougall testified that midazolam works for a couple of hours and the residual effects can persist for two to three hours. His expectation was that by the time Callie left Stage 1 recovery at about 11.00am, the effects of midazolam would be wearing off.[45] While he thought it possible that there could be a slight residual effect between 1.00 and 2.00pm, some five hours later, he expected Callie to be reasonably alert by this time.[46]

53. According to Dr McDougall, nurses working in recovery have specific training and routinely care for patients who have had an anaesthetic associated with a procedure of some sort. They have an expectation about how patients look in recovery and would bring to his attention any problems they perceive, or any departures or variances from the norm. A child would not be discharged if it was suspected they were still significantly affected by the anaesthetic. He could not recall any such concerns being raised with him about Callie.[47]

Callie's post-operative management

54. Callie's parents' concerns about her recovery from the anaesthetic continued throughout her admission to Stage 1 recovery, Stage 2 recovery and right up until her discharge and beyond. They are outlined in the parents' statements and reiterated in their evidence at inquest. Apart from

[43] Transcript pages 244-245.
[44] Transcript pages 246-250.
[45] Transcript page 251.
[46] See also RN Conroy's evidence about the expected effects of the pre-medication/midazolam and additional analgesia at transcript pages 310-311
[47] Transcript pages 251-254, 259-60.

concerns about her 'conscious state', already addressed to some extent above, their main concern was about the nature and extent of Callie's vomiting.[48]

55. With relation to these two concerns, there is a significant discrepancy between the parents' description of Callie immediately following the procedure and before her discharge, and the medical records and evidence of nursing staff who cared for her in recovery and the dietician who discussed changes in Callie's feeding regime with her parents. Questioning of the relevant witnesses about this aspect of the circumstances occupied significant time at inquest.

56. Callie's parents describe her vomiting frequently in recovery 'every 5-10 minutes', vomiting throughout the NGT feed, so much so that the feed had to be stopped and started numerous times.[49] In terms of the nature of the vomit, they described it as brown, red or comprised of mucous at times, and at other times the vomiting was non-productive, more like gagging.[50] While they found Callie's vomiting 'definitely concerning', they did not raise any concerns with Nurse Conroy. Firstly, according to the parents, Nurse Conroy was there when Callie was vomiting. In the second place, they had been told that the scope could irritate Callie's oesophagus and stomach and that vomiting was to be expected.[51]

57. Registered Nurse Amy Conroy (**RN Conroy**) was the primary nurse caring for Callie in Stage 2 Recovery. RN Conroy documented only one episode of vomiting in the medical records at the commencement of Callie's NGT feed at 1148 hours which she described as a scant vomit of brown mucous on the Fluid Balance chart, corresponding to a Baxter Retching Faces/Nausea Scale score

[48] Statement of Mr Griffiths-I'Anson at paragraphs 16, 17 and 21 at pages 38-39 of the inquest brief - *"I saw her continue to vomit multiple times. I cannot recall how many times Callie vomited…I felt concern as even it if had been x-rayed earlier, I had seen Callie commit multiple times since...I watched the nurse in the pink scrubs start a feed. Callie committed straight away so Natalia and I stopped the feed. The feed was stopped and started between Callie's vomiting."* Transcript page 90. First statement of Ms Griffiths-I'Anson at paragraphs 10 and 11 on pages 33 and 34 of the inquest brief – *"Callie has vomited what looked like brown blood a number of times and so she was administered anti-nausea medication…My concern with this is that the surgery had occurred at 8.30am and this time was now 1.00pm and Callie was still vomiting. This is also a concern because vomiting can move the tube…the feed had to be stopped and started between her vomiting."* Second statement of Ms Griffiths-I'Anson at paragraphs 8, 12 and 17 at pages 36.1 and 36.2 – *"I saw Callie commit dark brown blood up two or three times while in Stage 1 Recovery. I had seen her vomit after the previous procedures…Callie moved to Stage 2 Recovery. Callie continued to vomit repeatedly. I estimate that I saw her vomit about every five or ten minutes. Nurses were present. I did not see the nurses recording each occasion when she vomited…Callie had been vomiting since the surgery…I saw Callie continue to vomit, and her feed was started and stopped between her vomiting. I estimate this was between every 10 and 15 minutes, so about 4 to 6 times over the course of the feed."* Transcript pages 39-41.

[49] Transcript page 40.

[50] Transcript pages 41, 60-61.

[51] Transcript page 41.

of 4 under Observations time-stamped 1145 hours.[52] RN Conroy referred to the same vomit in her progress note time-stamped 1342 hours and no other.[53]

58. There are no notations in the observations or progress notes section of the medical records of any further (or later) vomiting on Callie's part made by RN Conroy or Registered Nurse Rachel Lazarus (**RN Lazarus**) who covered for RN Conroy for about half an hour from about 1230 hours while she took a meal break. Conversely, the range of notations made by both RN Conroy and RN Lazarus thereafter reflect an improvement and stabilisation in Callie's clinical presentation.[54]

59. RN Conroy gave evidence at inquest. In January 2018, she was in her second year of nursing going in to her third year with two years' experience working in post-operative recovery. RN Conroy had not nursed Callie before her procedure on 11 January 2018. Callie's care was handed over to her from RN Laura Elkerton who nursed her in Stage 1 Recovery and there was nothing particularly memorable or concerning conveyed to her during handover.[55] RN Conroy did not recall the parents raising any concerns with her about Callie's condition. If they had, she would have documented 'any real concerns' by which she meant any concerns which she could not explain herself based on her expectations of patients in Stage 2 Recovery.[56]

60. At inquest, RN Conroy maintained that the scant vomit she documented at the commencement of the NGT feed was the only episode of vomiting or bringing up of any fluids experienced by Callie while she was in her care.[57] When this occurred, RN Conroy paused the feed immediately and asked Ms Griffiths-I'Anson if this was normal for Callie, to which she responded 'it was normal

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[52] Inquest brief at pages 1169 and 1168 respectively. The Baxter Retching Faces (also known as the Baxter Animated Retching Scale) is a validated tool developed to assess and monitor the presence and severity of nausea in children. The scale is based on the appearance of the child's face to which values between 0 and 10 are attributed, 0 being neutral or pain-free and 10 being the highest level of pain. RN Conroy's explanation of the scale is at transcript page 315 where she described Callie's rating of 4 as indicating she was moderately nauseous. See also pages 316 and following where she explains the FLACC (Face, Legs, Activity, Crying, Consolability) scale for assessing pain. RN Lazarus' also gave an explanation of the Baxter Retching Faces tool and the FLACC at transcript pages 268 and following.

[53] Inquest brief at page 1133 – *"Tried to aspirate new NGT, unsuccessful. Contact OT4 who advised they xray and are happy with placement of NGT. Parents tried to start feeds however line was occluded, flushing well, fiddled with pump. Feeds commenced via NGT at 40mls/hr, pt began to gag, feeds stopped, pt vomited scant old blood and mucous. Mum advised pt would normally have mucous vomits during feeds at home. Pt settled sitting on Mum's lap. Vitally stable, afebrile. Travel forms given to parents. Dietician has given parents plan at home." [Emphasis added.]*

[54] Inquest brief at pages 1168-1169, 1130-1134.

[55] Note that at 1047 hours, RN Elkerton had documented an earlier vomit by Callie, presumably around the time of her handover from Stage 1 to Stage 2 Recovery which she described as "medium" under emesis amount and "Brown, old blood with fresh clots" under emesis colour/appearance.

[56] RN Conroy's statement dated August 2020 is at page 52 of the inquest brief. Transcript pages 296-298 and 332.

[57] Transcript page 303.

for Callie to vomit as feeds were being established'. Callie otherwise tolerated the NGT and there were no further vomits.[58]

61. In cross-examination by Ms Gold on behalf of the family, RN Conroy maintained that this scant vomit at the commencement of the NGT feed was the only time she saw Callie vomit. Moreover, given the set-up of Stage 2 Recovery, if she had missed another episode of vomiting, another staff member would 'definitely have seen it.'[59] As regards the omission of nausea scale assessments under Callie's observations time-stamped 1253 hours and 1315 hours, RN Conroy was confident that the rating would have been "0" otherwise she would have documented any parameter that was 'other than normal'.[60]

62. Finally, RN Conroy testified that she did not remember the parents raising any concerns with her about Callie's discharge. If the parents had been unhappy about Callie being discharged, she would have 'definitely documented and escalated' their concerns further.[61]

63. As mentioned above, Callie's nursing care passed to RN Lazarus[62] who covered RN Conroy while she took a meal break of about half an hour ending shortly after 1.00pm. According to RN Lazarus, staffing ratios are one nurse per four patients in Stage 2 Recovery which she described as a 'high turnover' area. There were therefore usually three nurses and a nurse in charge, and sometimes additional nursing staff or 'floaters' who helped to cover meal breaks and with other tasks. Although the ability to hear what was going on around you could fluctuate, and State 2 Recovery could be noisy at times, RN Lazarus testified that it would be unlikely that an unsettled child in discomfort would go unnoticed.[63]

64. In terms of its physical set-up, RN Lazarus described Stage 2 Recovery as an open area with 12 patient bays and a central nursing station.[64] Callie was connected to a monitor which alarmed when her heart rate went beyond 150 beats per minute. This alerted RN Lazarus who responded by documenting Callie's observations time-stamped 1249 hours. RN Lazarus could not say if she had tended to Callie before this occurrence.[65] Other than the elevated heart rate, the appearance that she was uncomfortable and wriggling in bed at the time (documented under Level of

[58] Transcript page 307, 345,347, 350.
[59] Transcript page 329.
[60] Transcript page 331, 345.
[61] Transcript pages 311-313, 345-346.
[62] Registered Nurse Rachel Lazarus' statement dated March 2021 indicates that she obtained a Bachelor of Nursing degree in 2009, was working at the RCH on 11 January 2018 and continued to work there as at the date of inquest.
[63] Transcript pages 282-283.
[64] Transcript pages 274-275.
[65] Transcript page 275.

Consciousness – Alert) and a FLACC/pain score of 4, Callie's observations were all within normal parameters.[66]

65. RN Lazarus returned a few minutes later to re-assess Callie and see how she was going. Having done so, she made entries time-stamped 1253 hours of a reduced and improved heart rate of 146 which was within normal parameters, and an improvement under Level of Consciousness – Alert to "appears more settled, resting in bed, NGT feeds continue".[67]

66. According to RN Lazarus, it was not the practice to document the fact that you were simply covering a colleague's meal break but it was the practice to continue to ensure that observations were documented half-hourly and to document any variances that occurred while you were covering. This would include any observation that Callie was dry-retching or coughing anything up, appeared limp, was not tolerating her feed, or that the feed had to be stopped and started. These were occurrences which if observed by her would have been escalated.[68]

67. Apart from the evidence of RN Conroy, RN Lazarus and Callie's parents in this regard, aspects of Dr Crameri's and Dr Kirby's evidence are relevant as providing context for Callie's vomiting such as it was.

68. Dr Crameri testified that the fact that Callie was vomiting following the procedure was not surprising as they had dilated her oesophagus, saw she had contact bleeding, but also recognised the potential for reflux or fluid coming up from the stomach in the early post-operative stage.[69] Further, Dr Crameri's evidence was that if he had been aware of the extent of vomiting according to the parents' accounts, he would certainly have enquired about the nature of the vomiting. While 'dry retching, trying to regurgitate, bringing up saliva and blood' would not be surprising and would not lead to a repeat x-ray, large vomits of gastric content that might potentially dislodge the NGT would warrant testing and aspirating, rather than a repeat x-ray, which ensue if aspiration was inconclusive.[70]

69. Similarly, Dr Kirby's evidence was that it is not particularly worrying if a child is vomiting or retching in the first hour or two after the procedure. In itself, this does not suggest an oesophageal injury or that the child could not be discharged that day. The germane issue is how the child is at the point of discharge – *"because if they'd been vomiting for anaesthetic reasons, or blood in the*

[66] Transcript page pages 275-277.
[67] Transcript pages 277 and 285.
[68] Transcript page 279-281.
[69] Transcript pages 149-150.
[70] Transcript pages 155-159.

stomach irritating the stomach … however upsetting it was for the child, and whether it was three vomits or 15, if that's now all better, and we now move forward another two hours, and the child is now tolerating feeds and no longer vomiting or retching. Then I don't think, in itself, it's the critical part of this story."[71]

The discharge plan

70. According to Dr Crameri, Callie's post-operative plan involved routine post-operative observations and for Callie to receive her usual bolus feed via the NGT prior to discharge home. Dr Crameri reviewed Callie twice after the procedure, including at the conclusion of his morning list when he noted that she was tolerating her feed and indicated to the family that he was happy for her to be discharged once the feed was completed.[72]

71. Given the family's concerns about discharge home, it is important to note Dr Crameri's evidence that the procedure on 11 January 2018 had been planned as a day procedure on the understanding gleaned from the earlier admission that this would be the family's preference. However, had Dr Crameri been aware on 11 January 2018 of the concerns expressed by Callie's parents in their statements and evidence at inquest, they 'absolutely would have been taken into account and he was confident an overnight admission could have been facilitated'. It was Dr Crameri's evidence that no such concerns had been communicated to him at the time.[73]

72. Callie's discharge plan as documented by the surgical team was for the 'NGT to remain in situ; dietician review today with view to resuming full NGT feeds to provide 100% of calories via NGT (discussed with dietician Kristen Fitzell); can still have oral feeds as tolerated; can go home after dietician review; and we [RCH] will organise for next oesophagoscopy and dilation.'[74]

73. It was not controversial at inquest that Mr and Mrs Griffiths-I'Anson had been instructed in the administration of NGT feeds to Callie prior to her discharge home on 5 January 2018; were able to prepare the feed at the required concentration; knew to test that the position of the NGT in the stomach prior to commencing the feed; and could administer the feed as directed.[75]

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[71] Transcript pages 387-388.
[72] Dr Crameri's statement at pages 13-14 of the inquest brief and transcript pages 163-164.
[73] Transcript pages 165-168.
[74] See operative note of Dr Florence Ngu time-stamped 10.32am on 11 January 2018 at page 69 of the inquest brief. See also, discharge summary prepared by Dr Victoria Fosdick, Junio Medical Officer, at 2.20pm on 11 January 2018 at page 66 of the inquest brief.
[75] Transcript pages 105-108. Note that the parents had unilaterally increased Callie's NGT feeds in the two days immediately before 11 January 2018 by re-introducing a daily bolus to make up for her poor oral intake reportedly due to pain on swallowing. While this was a concern as dieticians do not normally encouraged families to make

74. Given the discharge plan as documented on 11 January 2018, it was a requirement that Callie be reviewed by a dietician prior to discharge. Kristen Fitzell (**Ms Fitzell**) was one of the RCH dieticians who had reviewed Callie during her first admission and immediately before her discharge home on 5 January 2018.[76] Ms Fitzell was aware of Callie's 300gram or three per cent weight loss that she did not see as significant but rather associated with the parents' indication that Callie's oral intake had recently decreased due to pain. She also noted that other factors could account for slight variations in weight loss such as this.[77]

75. Although Ms Fitzell's notes were time-stamped 12.05pm, her evidence was that she would have reviewed Callie before this time. She testified that she would have spent probably 15 minutes by Callie's bedside at any time between 10.30 and 11.30am-12.00pm, and after a discussion with one of the surgical team about the treatment plan going forward.

76. Ms Fitzell understood that the procedure demonstrated Callie had ongoing oesophageal inflammation and bleeding so the plan was for her to have all her nutritional needs met by NGT feeds as it was anticipated she may not want to eat due to discomfort.[78] Her role was to ensure the family were advised about Callie's new feed regime, not to ensure the NGT was correctly placed, nor to determine Callie's suitability for discharge.[79] In summary, the new regime involved augmentation of feeds to ensure adequate nutrition by increasing the concentration of overnight feeds and introducing (or continuing) the daytime feeds initiated by the parents. The underlying hope was that this would rest the oesophagus and promote healing.[80]

77. Callie had already been medically cleared for discharge by Dr Crameri, subject to review by Ms Fitzell and tolerating a feed. As her primary care nurse, it was RN Conroy who, effectively, discharged Callie into her parents' care for the trip home.[81] While RN Conroy could not recall the

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changes without consulting a dietician, on 11 January 2018, Callie's parents reported that she had tolerated the additional feeds. Also, statement of RCH dietician Kristen Fitzell dated September 2020 at pages 49-521 of the inquest brief, especially at page 50.

[76] To be clear, the review was on 4 January 2018 ahead of discharge home the following day.

[77] Transcript pages 108-109. *"But also with um, different scales and whether or not children have been to the toilet beforehand there's all difference factors to think about with slight variations in weight, but the 3 per cent wasn't significant"*

[78] Transcript page 110-111, 114-116. I note that Ms Fitzell could not recall which particular member of the surgical team she had spoken too but she understood that the plan was to give Callie's oesophagus a bit more of a rest to promote healing.

[79] Transcript pages 119-121.

[80] Ibid.

[81] There was discussion at inquest about whether this was a doctor or nurse driven discharge. It is tolerably clear that the parameters for Callie's discharge had been set by the surgical team and it fell to nursing staff to ensure the parameters had been met before allowing the patient to be discharges – see transcript pages 335 *"Who makes the decision for discharge?--- Um, so there's – in the post-op notes there's generally, um, if there's anything specific for a patient to be discharged, otherwise as long as they're eating and drinking, um, their pain is under control, they're good for discharge.* Also paragraphs 70 and following above.

exact conversation when discharging Callie, she gave evidence based on her practice in this regard. She discussed pain relief, the residual effects of a general anaesthetic which could last the day and any post-operative instructions from the team. RN Conroy administered the stronger analgesic prescribed for Callie, being oxycodone (Endone), knowing that the family had a long trip home.[82]

78. RN Conroy was 'fairly certain' that RN Lazarus had prepared the discharge paperwork that she handed to the parents highlighting the hospital switchboard number that they could use to contact the RCH if they had any questions or concerns. She did not recall the parents raising any concerns or expressing any hesitations about Callie being discharged and would have definitely documented and escalated the matter if they had.[83] It was RN Conroy's practice, every time she gave discharge paperwork, to go over it, ask if there are any questions or concerns and give the parents time to answer as well.[84]

Callie's parents seek advice from RCH after discharge

79. As matters transpired, an important aspect of Callie's discharge was the contact number given to the family to call RCH for advice if needed. It was uncontroversial that RN Conroy had advised the family that the oxycodone given to relieve Callie's pain for the trip home would have worn off by the time they got home some four hours later.[85]

80. The parents gave Callie additional pain relief in the form of paracetamol enroute. When they arrived home at about 7.00pm, they checked the pH level, ascertained it was below 5 as required and started Callie's night-time feed through the NGT. Callie vomited at about 9.00pm and the feed was stopped to allow her stomach to rest. The feed was recommenced at about 10.00pm together with some paracetamol, after her parents once again checked the pH level. As Callie was pale and listless and could not keep her eyes open, Mrs Griffiths-I'Anson called the RCH switchboard on the number provided to her at discharge.

81. While Mrs Griffiths-I'Anson gave no account of what she said to the switchboard operator in her two statements, at inquest she testified that she could remember her exact words – *"she was still white as a ghost. She hadn't come good. She wasn't right. Something – something's not right and the – whoever I spoke to said that they would contact a surgeon and they would call us straight back."*[86]

[82] Transcript pages 308-309.
[83] Transcript pages 311-313.
[84] Transcript page 335.
[85] Transcript page 22 for Mrs Griffith's-I'Anson's evidence in this regard and transcript page 308-309 for RN Conroy's.
[86] Transcript page 35.

82. Callie's parents waited a while for the call but were exhausted and placed her in bed between them in an effort to sleep. Callie was very restless. Her mother woke whenever she moaned and rubbed her back until she went back to sleep. Callie was irritable and kept moving as if trying to get comfortable. They received no phone call back and woke at 6.00am to find Callie in extremis as outlined above.[87]

83. It was conceded by the RCH that the family received no call back from anyone at RCH before Callie's death the following morning. Dr Crameri advised that internal reviews conducted at RCH, indicated that the call had been put through to the on-call General Surgical Registrar (**the registrar**) who was involved in a major case and was scrubbed in the operating theatre. The Registrar noted the call when they completed the procedure but by then it was after 1.00am and they felt it was too late to call and planned to call first thing in the morning to see how the family was progressing. [88]

84. According to Dr Crameri's account, 'it did not appear from the message that the family had a significant concern'.[89] There is a significant gap in the evidence here as we do not know the content of the message received by the registrar and cannot appraise the reasonableness of their assessment that a call first thing in the morning would suffice and was preferable to a late call around 1.00am. Dr Crameri acknowledged how difficult it is for the registrar to grade the urgency of calls as they receive so many during the day about a variety of patient problems, many of which only require reassurance and could be addressed by nursing staff. There is usually a plan for nursing staff to attend to these calls but sometimes they too are involved in the operating theatre.[90]

85. It is apparent that the parents felt that calling RCH for advice was the right thing to do in light of Callie's recent procedure there and their understanding the RCH had specialist knowledge about her case. Given the relatively remote location of their home, in terms of access to tertiary medical care, they had limited other options, and this was a fact known to the RCH.

86. Dr Kirby commented about this aspect of the circumstances. He noted that it was not the simple distance between the RCH and the family's home that was important, as there is a large regional hospital in Albury some 105 kilometres from the family, much closer than the RCH. However, as matters played out the most significant factor for Callie was the location of the nearest paramedic

[87] See paragraphs 7-8 above.
[88] Dr Crameri's statement at page 16 of the inquest brief.
[89] Ibid.
[90] Ibid.

station which was some 40 minutes away. Dr Kirby characterised this as a problem of remoteness, rather than distance.[91]

87. By reference to other types of procedures, Dr Kirby testified that in stratifying the risk associated with a 'dilatation of the yet to be healed oesophagus', the patient should be sent somewhere where help is not too far away or to have a foolproof plan for the family to let you know if the child begins to deteriorate.[92] He characterised the issue as how to give a nuanced and educated response to a parent who is concerned about their child on the day of surgery (or thereabouts). Dr Kirby testified that this is a universal challenge with no simple solution, any solution is likely to be institution specific and he had yet to find a hospital that has the perfect solution.[93]

88. Dr Kirby gave examples of how other institutions addressed the issue. At his own hospital, the Women's & Children's Hospital, Adelaide, the paradigm was very similar to the RCH, Melbourne, with one important caveat. If the registrar receives a message after hours from a parent worried about their child who has been discharged that day, they must return the call whenever they become free, irrespective of the time of day and even if they think it is not likely to be something important. Dr Kirby conceded this was not foolproof or without its problems.[94]

89. He gave examples of two other hospitals which did not rely on the on-call surgical registrar. One hospital provides parents with the contact number of the paediatric emergency department where parents can speak to one of the doctors working the ED. The other hospital instructs parents to stay close enough to the hospital so that they can bring the child back to be reassessed. Dr Kirby felt both have the advantage of protecting the family from the possibility that the surgical registrar is task saturated. However, he felt that each had a disadvantage. If the parents' concern is about a surgical issue, an ED doctor is not necessarily going to find it easy to give a nuanced answer. On the other hand, if the problem could be solved over the telephone, Dr Kirby thought it is a bit rough on a family to have to get back in the car and drive to the ED only to wait to be seen.[95]

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[91] Transcript pages 364-365.

[92] Transcript page 366-367, 369. See especially Dr Kirby's evidence at page 366 – *"Well, if we can look at the easiest of all extremes is children having tonsillectomies where the risk if that they might have a second bleed which might obstruct their airway six hours or eight hours after the operation, so they cannot go home. Children having tonsillectomy stay where they can have immediate care. Now clearly having instrumentation of a damaged oesophagus is not at that level of something suddenly going wrong, but if something is going to go wrong it's likely to make the child progressively sicker usually over the course of 24 hours, sometimes even 48 hours. But they can become profoundly unwell; sepsis and clearly, as has played out here…"*

[93] Transcript pages 368-9.

[94] Ibid.

[95] Transcript page 369.

FINDINGS/CONCLUSIONS

90. 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. [96]

91. Adverse findings or comments against individuals or 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.

92. Having applied the applicable standard of proof to the available evidence, I find that:

    a. The identity of the deceased is Callie Griffiths-I'Anson born 15 October 2015.

    b. Callie died at Corowa District Hospital, New South Wales on 12 January 2018.

    c. The medical cause of Callie's death is perforated oesophagus secondary to complications of treatment of oesophageal injuries following caustic soda ingestion.

    d. The initial injury to Callie's oesophagus was caused by her ingestion of caustic soda at the Oaklands Hotel on 11 December 2017.

    e. The oesophagoscopy and dilatation procedure Callie underwent at the Royal Children's Hospital, Melbourne, on 11 January 2018 was performed in accordance with current best practice.

    f. Nevertheless, Callie suffered an iatrogenic perforation of her oesophagus during or as a result of the procedure that led to her death about 24 hours later.

    g. The available evidence does not enable me to determine precisely when or at what stage of the procedure Callie's oesophagus was perforated or whether the mechanism of injury was a direct or indirect result of the procedure.

    h. The state of Callie's oesophagus on 11 January 2018 was largely a function of the severity of the initial injury and contributed to her death.

    i. Callie's post-operative clinical course prior to discharge was unexceptional.

[96] Briginshaw v Briginshaw *(1938) 60 C.L.R. 336 especially 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…"*

j. To the extent that Callie's parents raised concerns with nursing staff about her post-operative state, the nurses' attribution of that state to the midazolam administered to her as pre-medication and the expected effects of undergoing a general anaesthetic were reasonable.

k. To the extent that there is inconsistency between the parents' description of Callie's post-operative state and the medical records and nurses' evidence, I prefer the evidence of the latter.

l. Specifically, I find it inherently improbable that Callie could have been as unwell as the parents describe (taking their evidence at its highest) without attracting the attention of nursing staff and eliciting an appropriate clinical response or escalation.

m. At the point of Callie's discharge there was no clinical indication that she was unwell, unsuitable for discharge or had suffered an iatrogenic perforation or other complication of the procedure.

n. The discharge plan as documented in the medical record and as explained to the parents prior to discharge was reasonable and appropriate.

o. It is likely that the parents' observations of Callie's deterioration on the evening and overnight on 11-12 January 2018 reflected the cascading effect of the iatrogenic injury and consequential infective process to which she ultimately succumbed.

p. Mrs Griffiths-I'Anson's call to the RCH at about 10.00pm on 11 January 2018 seeking urgent medical advice was met with a wholly inadequate response, indeed no response.

q. Whether this inadequacy caused or contributed to Callie's death is unclear as it depends on precisely what was communicated by Mrs Griffiths-I'Anson, how that was heard or interpreted by the call-taker and the on-call General Surgical Registrar to whom the call was directed, and how quickly Callie could have accessed emergency medical treatment.

COMMENTS

Pursuant to section 67(3) of the ***Coroners Act 2008***, I make the following comments connected with the death/s, including matters relating to public health and safety or the administration of justice:

1. The circumstances in which Callie died highlight the realities of living in a regional area where emergency tertiary medical care may not be as readily accessible as in metropolitan areas, and where the tyranny of distance may in some cases contribute to the death of a loved one.

2. The investigation into Callie's death suggests that there is no simple solution to the problem of families accessing specialist nuanced advice following discharge and in the early post-operative period when uncommon or rare complications, occult iatrogenic injury or infective processes may be developing.

RECOMMENDATIONS

Pursuant to section 72(2) of the ***Coroners Act 2008***, I make the following recommendations, including recommendations relating to public health and safety or the administration of justice:

1. Recognising the inherent challenges in finding a solution, I recommend that the Royal Children's Hospital considers the circumstances in which Callie died and the failure of the process for accessing advice from the on-call General Surgical Registrar about a child who had undergone a recent procedure, with a view to developing a better process.

2. In developing a better process, I recommend that the Royal Children's Hospital considers:
    a. The qualifications of the person who takes such calls in the first instance.
    b. The use of technology to re-route calls.
    c. Early triaging or differentiation of such calls.
    d. The use of structured questioning to elicit as good clinical information as possible.
    e. The particular vulnerability of children living in regional or remote areas.
    f. The provision of a discharge summary and/or formal handover of the child to the nearest regional hospital for follow-up.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, unless otherwise ordered by the coroner, the findings, comments and recommendations made following an inquest must be published on the internet in accordance with the rules. I make no such order.

DISTRIBUTION OF FINDING

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

The Griffiths-I'Anson family

The Royal Children's Hospital, Melbourne

NSW State Coroner

Senior Constable Matthew Smith, Corowa Police Station, New South Wales

Signature:

Coroner Paresa Antoniadis Spanos

Date: 27 June 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.