MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of FL

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is FL;

b) FL died in the circumstances set out below;

c) The cause of FL's death was hypoxic brain damage from an out of hospital cardiac arrest; and

d) FL died on 13 July 2020 at the Launceston General Hospital, Launceston, Tasmania.

Introduction

1. In making the above findings I have had regard to the evidence gained in the comprehensive investigation into FL'S death. The evidence includes:

- Tasmanian Health Service – Death Report to Coroner;
- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Report – Dr Christopher Lawrence, Forensic Pathologist;
- The results of toxicological analysis of samples taken at autopsy;
- Records - Ambulance Tasmania;
- Medical Records – Norwood Medical Centre;
- Medical Records – Tasmanian Health Service – Launceston General Hospital;
- Medical Records – Royal Children's Hospital, Melbourne;

- Records – Launceston Christian School;
- Records – Child Safety Services;
- Interview with EU, mother of FL;
- Interview with RV, partner of FL's mother;
- Affidavits of family, friends and teachers;
- Affidavits of attending and investigating police officers; and
- Forensic and photographic evidence.

Background

2. FL was born in Hobart on 6 December 2002. At the time of his death, he was aged 17 years and living with his mother EU in the Launceston suburb of Waverley, Tasmania. Although his parents separated in 2013, his father HM remained an important part of his life. FL had four younger brothers.

3. He was born at 34 weeks with an extremely rare birth defect, gastroschisis. The condition is characterised by the baby's intestines extending outside of the abdomen through a hole next the navel.

4. FL's birth defect required immediate, complex and ongoing medical treatment. Shortly after his birth he had surgically removed sections of both his small and large bowel, leaving him with a condition known as "short bowel syndrome". The effect of short bowel syndrome was FL's ability to consume normal food was significantly compromised. This in turn impacted adversely upon his growth, development and general health.

5. In 2007, the family moved to Melbourne, Victoria to ensure FL had the appropriate medical treatment at the Royal Children's Hospital, Melbourne.

6. In 2016, to address the effects of his short bowel syndrome, FL had a Central Vascular Access Device surgically implanted into a vein close to his heart. The device enabled him to be provided with sterile nutrition – Total Parenteral Nutrition (TPN).

7. His parents underwent training in relation to the safe administration of TPN.

8. After EU and HM separated, EU returned to Launceston with FL and the other boys. She had two more sons with RV.

9. FL's complex medical requirements were managed by the Royal Children's Hospital in conjunction with the Launceston General Hospital.

FL's circumstances leading up to his death

10. At the time of his death, FL was 17 years and seven months old. Enrolled as a student at the Launceston Christian School, his education had, like every other young person his age in Australia, been significantly impacted by the COVID-19 pandemic. It had been several months since he had been to school for "face to face" learning.

11. Another result of the pandemic was access to conventional medical appointments was limited and significant reliance placed on so-called "tele-health" consultations.

12. At the same time, FL was, like most 17 year old young people, trying to take more responsibility for his life and, in his case, medical care. In March and April 2020 he assumed a greater level of responsibility for looking after his nutrition line.

13. By mid-May, his mother noticed he appeared to be suffering from a run of viral type illnesses including runny noses, sore throats, and the like. EU sought advice from the Royal Children's Hospital who suggested, apparently, he may have glandular fever which could be confirmed by a blood test. I note that his records at the Launceston Christian School indicated, on 23 March 2020 EU rang the school and advised FL was being kept home and being tested for glandular fever. That diagnosis was "confirmed" to the school by his mother on 31 March 2020. In fact, FL was not taken for a blood test and no diagnosis of glandular fever made. I note that at autopsy no clear evidence of any viral infection was found.

14. FL's health continued to deteriorate. He remained bedridden and suffered a fall on his way to the toilet. His mother assumed all responsibility for his TPN line management. He developed bedsores and required assistance to walk to the toilet. EU subsequently told investigators that she attempted to persuade FL to go to the doctor but he "started flipping right out and didn't want to go". FL was not taken to a doctor or to a hospital.

15. During June 2020, FL received visits at home from a social worker and a teacher employed by the Launceston Christian School. Both observed him to be extremely weak and extremely unwell. The social worker described FL's appearance when he

visited on 12 June 2020 as "confronting". Apart from praying with and for him, it seemed neither the school social worker nor teacher actually did anything about the fact that FL was obviously gravely ill.

16. In the week or so prior to his admission to the Launceston General Hospital, FL reportedly had a choking episode on a tablet.

Circumstances of Death

17. On 2 July 2020 EU gave FL a glass of water before leaving the room for two minutes. Upon her return she found him gagging and choking before becoming unresponsive. Ambulance Tasmania records indicate that at 11.08am EU telephoned 000. An ambulance was dispatched and arrived 10 minutes later. Ambulance Tasmania paramedics found FL lying semi recumbent in bed with no apparent breath and a weak carotid pulse. CPR was immediately commenced and circulation was able to be restored after 11 minutes but lost again four minutes later. FL was treated with adrenaline, followed by further CPR, followed by more adrenaline before he was rushed to the Launceston General Hospital. He was admitted to the hospital's Intensive Care Unit, via the Emergency Department.

18. Despite ongoing post-cardiac arrest management including 24 hours of targeted temperature management, circulatory and ventilatory support, FL did not improve. On 13 July 2020 he died at the Launceston General Hospital.

Investigation

19. FL's death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified by a member of the Launceston General Hospital staff. It was then taken by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital experienced forensic pathologist Dr Christopher Lawrence conducted an autopsy.

20. At autopsy, FL was found to weigh 75 kg (not evidence to my mind of malnutrition), and whilst his body had signs of medical intervention and some signs of injury associated with being bedridden, there were no signs of violence or injury as such.

21. In his detailed report, Dr Lawrence expressed the opinion that the cause of FL's death was a hypoxic brain injury caused by an out of hospital cardiac arrest. Significant contributing factors included his short bowel syndrome (due to gastroschisis) and liver, pancreatic and spleen dysfunction due to long-term total parenteral nutrition (all due of course as well to gastroschisis). Dr Lawrence also

noted the presence of significant ulceration pressure areas, clearly attribute to a lengthy period bedridden.

22. Dr Lawrence suggested that there were several possible explanations for the cardiac arrest which ultimately caused FL's death. Those possible causes included:

    a. the aspiration of gastric contents;

    b. sepsis from his catheter; and

    c. liver, pancreatic and spleen dysfunction due to long-term total parenteral nutrition.

23. I accept Dr Lawrence's opinion as to the cause of FL's death.

24. Dr Lawrence was unable to say definitively what the cause of FL's cardiac arrest was other than to say it was not due to methadone as had been initially suspected.

25. Toxicological analysis of *ante mortem* blood samples was carried out at the laboratory of Forensic Science Service Tasmania. Results of that analysis were unremarkable. No alcohol or illicit drugs were detected as having been present at the time FL was admitted to the Launceston General Hospital. Specifically, no methadone was detected.

26. I am affirmatively satisfied that FL had no methadone in his body at the time of his admission to the Launceston General Hospital and that drug played no role in his death.

27. It would seem that the presence of methadone was suspected as a result of a urine test shortly after admission. A false positive result in such circumstances is possible, and in light of the definitive evidence from the laboratory of Forensic Science Service Tasmania, it must be the explanation in this case.

Conclusion

28. I am satisfied that there are no suspicious circumstances associated with the death of FL.

Comments and Recommendations

29. The circumstances of FL's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

30. The professional and thorough investigation of Detective Senior Constable P J Barrett, Tasmania Police, is worthy of particular recognition.

31. I convey my sincere condolences to the family and loved ones of FL.

Dated: 18 February 2022 at Hobart in the State of Tasmania.

Simon Cooper
Coroner