CITATION: *Inquest into the death of Bradley Abala* [2005] NTMC 035.

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0031/2004
DELIVERED ON:	27 June 2005
DELIVERED AT:	Alice Springs
HEARING DATE(s):	3, 4 May 2005
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

REPRESENTATION:

Counsel:	
Assisting:	Ms Helen Roberts
Department of Health and Community Services:	Mr Roger Bennett

Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0031/2004

In the matter of an Inquest into the death of

BRADLEY PAUL ABALA
ON 23 APRIL 2004
AT THE INTENSIVE CARE UNIT
ALICE SPRINGS HOSPITAL

FINDINGS

(Delivered 27 June 2005)

Mr GREG CAVANAGH SM

1. Bradley Paul Abala ("the deceased") died at Alice Springs Hospital on 23 April 2004. He was a much loved child and part of a large extended Alice Springs family.

2. Section 12(1)(a) of the *Coroners Act* defines a "reportable death" to include a death "that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury". For reasons which will appear in these findings the deceased's death was considered "unexpected" and therefore reported to the Coroner. I determined to hold an inquest in this matter pursuant to my discretion to do so provided by s.15(2) of the *Coroners Act*.

3. Section 34(1) of the *Coroners Act* details the matters that a Coroner is required to find during the course of an investigation into a death. That section provides:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
> (ii) the time and place of death;

(iii) cause of death;
(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;
(v) any relevant circumstances concerning the death."

4. Section 34(2) provides further:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

5. The evidence tendered at the Inquest included the brief of evidence prepared by the investigating police officer; additional statements of Dr Terry Coyne and Nurse Jocelyn Piper; and the hospital file. Exhibit 5 is a document titled "Mother's concerns and questions" comprising matters raised in writing after the oral evidence, by the family of the deceased about their child's death.

6. Counsel assisting me at this Inquest was Ms Helen Roberts. Mr Bennett appeared on behalf of the Department of Health and Community Services, specifically the Alice Springs hospital. Several of the deceased's family attended Court. They were not legally represented, however they conveyed to Ms Roberts the questions that they wished asked of the witnesses who were called to give evidence. They also raised in Exhibit 5 and previous correspondence other matters which they asked me to consider in these findings.

FORMAL FINDINGS

7. On the basis of the all of the evidence I am able to make the following formal findings.

(a) The identity of the deceased was Bradley Paul Abala, born on 28 December 1991 at Alice Springs Hospital.

(b) The place of death was the Intensive Care Unit at Alice Springs Hospital and the time of death was 9.25 am on 23 April 2004.

(c) The cause of death was astrocytoma.

(d) The particulars required to register the death are:

1. The deceased was a male.

2. The deceased was an Australian citizen of Aboriginal origin.

3. The death was reported to the Coroner.

4. A post mortem examination was carried out on 26 April 2004.

5. The pathologist viewed the body after death, and the pathologist was Dr Paull Botterill of the Royal Darwin Hospital.

6. The mother of the deceased is Sharon Donnellan.

7. The father of the deceased is Bradley Abala.

8. The deceased lived at 44 Plumbago Crescent, Alice Springs, Northern Territory.

CIRCUMSTANCES

8. The deceased was born on 28 December 1991 at Alice Springs Hospital. He developed normally and was a keen sportsman. In January 2004, he started having headaches which his mother treated with panadol and sleep. By March, she had noticed that he was off balance and suffering coordination difficulties when playing basketball. About three weeks before his death he had a severe headache at school and he fell asleep and was difficult to wake. On Tuesday 20 April 2004, he again fell asleep at school and that evening his mother took him to Alice Springs Hospital Accident and Emergency Ward.

9. The doctor who saw him that evening noted a history of headaches associated with lethargy, nausea and some loss of coordination. A CT scan was performed and the deceased was discharged with an arrangement for a

specialist review the following day. The scan revealed a posterior fossa tumour with associated enlarged ventricles (hydrocephalus). At around 9.00am on the morning of 21 April 2004, the deceased's mother was contacted and asked to bring her son in. She saw Dr Tors Clothier, a paediatrician. She was told that her son had a tumour on the left side of his brain and that he would require a complex operation. Another CT scan was performed which showed no change in ventricular calibre since the night before. The deceased was admitted to hospital and it was decided that he would be transferred to Adelaide the next day for surgical intervention. The decision about the transfer to Adelaide was made in consultation with a neurosurgeon at Adelaide Women's and Children's Hospital. Neither the specialists nor the facilities to perform the brain surgery that the deceased required are available at Alice Springs Hospital. Accordingly, it is and was usual to fly such patients to Adelaide for surgery.

10. The deceased appeared to be well until relatively late in the evening on 21 April 2004, playing with his cousins who had come to visit. Overnight, however, his condition deteriorated dramatically and he was discovered not breathing at 6.00am. Although he was resuscitated, brain death was confirmed at 2.00pm on 22 April 2004. He remained on life support until 9.25am on 23 April 2005.

11. The deceased's mother, Sharon, was understandably shocked and extremely distressed when, having left her son in apparently reasonable health the previous evening (albeit with a serious illness), she was telephoned to be told that his condition was irretrievable early the following morning. The concerns and questions that have been raised throughout by the family include:

    1. Why a decision was not made to transfer him to Adelaide immediately the tumour was diagnosed;

2. Why a decision was not made to carry out some treatment, and/or urgent transfer, after his condition began to deteriorate at about midnight the evening before he died;

3. Why he was not more closely observed during the night;

4. Why his mother was not notified when he become very ill overnight.

12. The deceased was first diagnosed with a brain tumour on the morning of 21 April 2004, the day after his mother had brought him into the hospital because of her concern about his symptoms. At that time, Dr Clothier, his treating doctor, consulted with a neurosurgeon in Adelaide about when it was most appropriate to transfer the deceased. The decision was made in consultation with that doctor to admit the deceased overnight and to transfer him to Adelaide the following afternoon.

13. The Coroner's Office sought the opinion of Dr Terry Coyne, an independent specialist from Brisbane about this question and the management of the deceased generally. Dr Coyne has been a specialist neurosurgeon since 1991 and is currently a practising neurosurgeon with appointments at various public and private hospitals in Brisbane, Queensland. In addition, he has an academic appointment at the University of Queensland and has published several peer reviewed papers in the area of neurosurgery. He reviewed the brief of evidence available to the Coroner, and in his report dated 15 September 2004 he said:

> "Bradley's condition was irretrievable from the time his cardiac arrest was discovered. The only intervention which could have assisted Bradley would have been for him to have had a neurosurgical procedure to treat his hydrocephalus prior to his cardiac arrest. It seems unlikely this could have been provided at Alice Springs Hospital. Therefore, for Bradley's sudden deterioration to have been avoided, it would have been necessary to transfer Bradley on an urgent basis to a neurosurgical centre following diagnosis. It is noted that the medical staff at Alice Springs Hospital discussed Bradley's condition and received advice from a neurosurgical centre. At the time this discussion took place,

> Bradley was neurologically well, and there had been no progression of hydrocephalus in the interval between the CT scans of 20/4/04 and 21/4/04. While the potential for sudden deterioration with posterior fossa mass lesions is always in the mind of a neurosurgeon, **the relatively low risk of this occurring** (my emphasis) has to balanced against the difficulties of an urgent transfer. Even had Bradley arrived in Adelaide on what would likely have been in the late afternoon or evening of the 21/4/04, as he was still in good neurological condition it is likely that surgical treatment of his hydrocephalus would still have been planned for the following day."

14. Dr Coyne explained in evidence that a number of factors would be taken into account were he to be making the diagnosis and assessing the deceased for the risk of immediate deterioration. One factor was the three month history of headaches (transcript p12):

> "I think you've noted here, 'A 3 month history of increasing headaches and incoordination.' How would that factor into your diagnosis if you'd been in the position of doing a diagnosis?---Well just in the terms of urgency or the risk of rapid deterioration, the history gives a little bit of an idea how rapid the process is occurring. So if someone presented unwell with a several day history that may suggest the problem is more urgent than if someone had presented with a history over a number of months or many months. So it just gives a little bit of an idea of the aggressiveness of the underlying process and how likely any deterioration is about to occur."

15. In addition, the two CT scans showed no change in ventricular size. This was significant because a change in ventricular size maybe an indicator in imminent deterioration. Further, Dr Coyne said that in addition to those two factors and probably more importantly, he would take into account the child's presentation at diagnosis. He said (transcript p13):

> "…Yes. Yes, I think in terms of trying to work out when to send the child for definitive treatment the fact that there was a relatively long history and that he was – appeared neurologically well and alert and playing with his relatives, they're sort of indicators that perhaps things aren't immediately critical, just at that instant in time."

16. His conclusion was that on the basis of all the information available, the decision that was made to transfer the child the following day was a

reasonable one. Dr Coyne said that he believed that if he had been phoned with the same information he would (transcript p14):

> "…probably would have said just that the, you know, next available transfer would be reasonable. Obviously in hindsight that didn't work out that way, but I think what happened was extremely – an extremely low likelihood of happening at that particular time, based on the history provided."

I also have before me Exhibit 4, a report prepared by Mr Peter Scott, a senior consultant surgeon at Royal Melbourne Hospital. Mr Scott prepared a report at the request of Mr Chris Howse, Counsel for the Aboriginal Justice Advisory Committee. Mr Howse, as I understand it, commissioned the report as part of his consideration as to whether he would seek leave to appear at this Inquest. Mr Howse informed the Deputy Coroner that, on the basis of the report by Mr Scott, he had determined that he would not seek leave to appear. Mr Scott had examined the brief of evidence provided to Mr Howse by my office. In relation to the specific issue of the timing of the transfer Mr Scott said this (page 3):

> "It is worth noting that the CT scans performed on the day he was first seen at Alice Springs Hospital and the day after, showed no worsening of the obstructive hydrocephalus and at that stage, in the absence of any vital signs to suggest otherwise, and most particularly as the patient was oriented and happy and playing with members of his family, it was felt that transfer the following day would be appropriate."

He summarised his overall opinion this way (page 3):

> "…**it appears that all appropriate measures were taken in the management of the patient at Alice Springs Hospital**." (my emphasis)

17. The decision having been made for transfer the following day, the deceased was to stay in Alice Springs hospital overnight. Dr Clothier saw the deceased at about 7pm before he finished work for the day; at that time Bradley was "playing with his cousins and seemed pretty well". At

midnight, however, Nurse Jocelyn Piper became so concerned about Bradley's symptoms that she telephoned Dr Clothier at home. She told him the deceased had vomited, and was pale and unable to sit up without assistance. He was also calling himself "Memphis". She had checked with his cousin whether this was a nickname but apparently it was not, indicating he was confused. Dr Clothier then spoke to the Registrar, Dr Campbell, and asked him to go and examine the deceased, including a neurological examination. The results were reported back about half an hour later to Dr Clothier, to the effect that the deceased was at that time, fully conscious and oriented. The deceased was then moved to a ward where he could be under closer observation and was to be given full neurological observations four hourly. Dr Clothier also told Dr Campbell that if there was any more vomiting or confusional events, then they would consider the administration of Mannitol or Dexamethasone. (Those drugs are emergency treatments, most useful to slow the pressure on the brain in a situation where neurosurgical intervention is imminent.) At about 4.00am, the deceased had a full neurological observation which resulted in a Glasgow Coma score of 15:15 (fully conscious). That was his last neurological examination. Nurse Piper was doing more frequent visual observations, about half hourly. The last of these was at 5:30am. At 5.55pm she found him not breathing.

18. Dr Coyne explained that the symptoms of vomiting and confusion which occurred shortly prior to midnight the night before his cardiac arrest, were an indication of the commencement of "coning" (transcript p13). Doctor Botterill explained that the tumour swells and compresses areas of the brain or to the point that the brain stem is injured and breathing ceases (page 33). The deceased's family are very concerned about the lack of more frequent observations during this time, and the fact that their son was in a position where he could be not breathing for up to 30 minutes without being observed. I understand their concerns, and I note that Nurse Piper was herself so concerned that she took the initiative to call Dr Clothier at home.

In these circumstances, the family feel that some consideration should have been given to getting their child on a plane overnight so that he could travel to Adelaide and have rapid urgent neurosurgical intervention. Ms Roberts, on behalf of the deceased's mother, specifically asked Dr Coyne whether an urgent flight, would have made a difference. Dr Coyne answered the question this way (transcript p17):

> "…But the question is would anything have been achieved in relation to prolonging his life if he'd been put on a flight between 4 am and 6 am to Adelaide?---I think the chances are low. I mentioned in my – the second page of that report that possibly there could have been aggressive – if the decision was made that he was – there was concern that he was deteriorating and he was, you know, should be transferred to Adelaide as soon as possible it's possible that he could have been aggressively resuscitated prior to the terminal event, by being intubated and ventilated and given [mannitol], which is a medication to help remove fluid from the brain and decrease pressure on the brain. And just perhaps a very outside chance that if those things had happened and he'd been managed to get to a neuro-surgeon who could perform that ventricular drainage within a few hours of 4 am there's a very outside possibility that things could have been different. But I think practically even if he left Alice Springs from – at sort of 4 am or 5 am - - -
>
> THE CORONER: Well it's a 2 hour flight?---**By the time he was in a neuro-surgical operating theatre in Adelaide I think it would have been too late, is the most likely outcome."** (my emphasis)

19. All three medical experts, that is Doctors Coyne, Scott and Botterill, have said that from the time that the deceased commenced his deterioration the only thing that may have made a difference was rapid and immediate neurosurgical intervention. That intervention was not available at Alice Springs Hospital. Even had that intervention occurred, again all the medical evidence is consistent on the point that this may not necessarily have resulted in the deceased's recovery. Each of the doctors make reference to the fact that it is dependent upon the exact type of tumour that the patient has. In his report, Dr Coyne said (page 2):

> The documentation provided did not refer to the ultimate histological diagnosis of Bradley's brain tumour. Had for whatever reason Bradley got through his initial crisis related to hydrocephalus, he would likely have been facing the risks of major neurosurgical procedure to treat the tumour mass, the risks associated with the natural history of the tumour itself, and depending on the final diagnosis, risks associated with potential additional treatments such as radiotherapy or chemotherapy.

20. The initial provisional diagnosis suggested that the deceased had a pylocidic astrocytoma. In Dr Botterill's opinion, the tumour was a more aggressive tumour than was first thought, of a type which would be expected to have a poor prognosis, even if the deceased had initial successful intervention.

21. As the events occurred, unfortunately the deceased never had the opportunity to have the initial treatment that he required. It is understandably distressing for the deceased's mother and family to know that he was so critically ill over the night of 21 and 22 April 2004, and that they were not there with him. From the perspective of the deceased's family, this child was not being treated with the care and attention he required. His mother feels that had she been there, she could have ensured that everything possible was being done to attempt to save her son, even if it was ultimately in vain.

22. Dr Clothier was specifically asked about his decision not to contact the deceased's mother when he was, himself, contacted about the deceased being ill by Nurse Piper. I quote (transcript p24):

> "Did you consider ringing Bradley's mum or anyone in the family at around midnight, was it, that - - -?---Yeah, I did, but clearly when Dr Campbell came back to me and said, 'Look, he's fully recovered,' I thought well it's, you know, 1 o'clock in the morning, they've got to fly to Adelaide tomorrow, that it probably was not necessary to phone her. Obviously I regret not doing – having done that at the time, but I – yeah, I just didn't think it was a reasonable thing to do. I'd seen other children with brain tumours have acute confusional events and, you know, recover and go on subsequently to have the tumour removed.

> THE CORONER: I just want to be blunt about this, you didn't call the mum?---No.
>
> Because you didn't think right then and there that evening and in the early hours of that morning that he was dying?---No, I didn't.
>
> You would have called her if you thought he was?---Absolutely, yes. I didn't and I would have obviously acted differently if I did.
>
> You understand, you see, it's a matter of concern for the mum now?---Yes, I can understand.
>
> As it would be?---Yes, I quite understand.
>
> She didn't get called by the hospital to the bedside of her son?---No, I can fully understand that and, as I say, with 50/50 hindsight I wish I had called her, but I – you know at the time it seemed an unreasonable thing to do."

23. Dr Clothier was clearly sensitive to the concerns of the deceased's family, and himself upset by the death of this young boy. As Mr Bennett on his behalf submitted, and I agree, he answered questions candidly and honestly. Based upon the reported neurological examination, and his past experience, he believed that the deceased had recovered from the "confusional event" and that he would be going to Adelaide on a plane the next day for his surgery. It was on that basis that he made the decision not to contact the deceased's mother. It is clear that Ms Donnellan feels very strongly that she wished that she could have been there with her son, even if it could not have altered the sad outcome. It is to be regretted that she was not given this option.

24. I find that all appropriate medical care was given to the deceased within the available resources of the Alice Springs Hospital. I adopt the conclusions of the two independent experts, that the decision made to transfer the deceased to Adelaide the following day after his admission was a reasonable one. The likelihood of what occurred, occurring on that particular night, was very small and was not indicated by the history and examination findings. Once that decision had been made, it is the unfortunate case that there was

nothing that could be done to save the deceased's life once he became critically ill over the early hours of the morning of 22 April 2004.

25. I make no further comments nor any recommendations in relation to this death.

Dated this day of 2005.

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GREG CAVANAGH
TERRITORY CORONER