Review of the Record of Investigation into Death (Without Inquest) of Alby Fox Davis

In March 2018, 3-year-old Albie Fox Davis died whilst waiting for Ambulance care, in his mother's arms at their home in Wynyard Tasmania. Albie, who was soon to turn 4 was playing with the bouncy ball only a few feet from his mother. The ball was larger than a 50-cent piece and was recommended for his age group as a toy but it became lodged in his airway.

His mother (who had regularly and recently) been trained in first aid (based on ANZCOR recommendations), frantically tried to relieve the obstruction. All these attempts failed until she was forced to attempt 16 minutes of unsuccessful CPR on her own child, which also failed to relieve the obstruction.

The investigation into the death of Alby did not go to a formal inquest nor were any findings or recommendations made outside of the fact that it was a tragedy. No investigation was conducted as to whether it was preventable if there are any questions to be asked as to why the ANZCOR measures executed with competence by his mother failed to do what they were assured to be effective at i.e. removing an upper airway obstruction and preventing death. The magistrate, acting as the coroner on so many levels to appropriately acknowledge or address the preventability of this event. Not in regard to the mother's actions under duress, but into why when first-aid measures that are promoted and boasted about in Australia as evidence-based and superior to international consensus and evidence review turn out to have no efficacy in a straightforward case.

"In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Alby's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records; forensic and photographic evidence; and a report of an investigation conducted by the Office of Consumer Affairs and Fair Trading."

The first and primary error that the magistrate has made in this case is that a formal inquest was not conducted. As a result, a 'comprehensive investigation" was not conducted as suggested in his opening statement. While evidence was sought and received from the forensic pathologist, police, witnesses, and the Office of Consumer Affairs and Fair Trading, there was no expert clinical evidence and no detailed examination of the failure points that led to the death of Alby; and in particular why first aid measures failed, and appropriate ambulance response was delayed. There is no detail in the

report as to why there was a requirement for 5 paramedics (3 separate responses) on the scene, and 3 paramedics (2 responses) until clinical care was effective at relieving the obstruction. As to why the efforts of the initial response or if there was a lack of clinical skills and equipment to manage this type of airway emergency were never investigated.

"Alby died, aged 3 years, 11 months, and 22 days, when on Monday 26 February 2018 he choked on a small rubber 'bouncy ball'."

As evidenced by the picture produced by Alby's family after the incident, the 'bouncy ball' could not be considered 'small' or of a usual size that might present a choking hazard. In fact, all advice to parents and carers assumes that an object of less than the size of a 20-cent piece is the critical size to cause choking in a child and that objects of a larger size are therefore "safe" and compliance with Australian safety regulations. There is no doubt that Alby's mother had taken this advice into account in selecting the size of the 'bouncy ball' to purchase for the birthday celebrations. What is missing from a true investigation is that this abnormally large and unusual obstruction was only precipitated by the manner in which Alby was playing with the ball i.e. bouncing it against a wall and attempting to catch the ball in his mouth.

Out of his mother's sight for only a brief time Alby seems to have placed the ball in his mouth and swallowed it. The ball became lodged in his throat. His mother made frantic efforts to dislodge it, but could not. She called Ambulance Tasmania at 3.29 pm and continued her efforts to dislodge the ball and perform CPR until the first paramedic arrived 14 minutes later. He took over attempts at resuscitating Alby.

While it was evident, that although distressed, Alby's mother had been repeatedly trained and was competent in the application of first-aid measures recommended under the ANZCOR guidelines. However, despite her absolute faith in these measures that she assumed were evidenced, tested, and had efficacy in practice; none of these measures made any difference in relieving this severe obstruction. After the failure of multiple attempts using recommended measures, Alby became unconscious and she commenced CPR, which she continued for 14+ minutes until the arrival of the first paramedic, who was unable to relieve the obstruction. As there is no relevant evidence that CPR has any efficacy in the relief of severe upper airway obstruction (other than in already deceased patients) or that any perfusion is provided to the patient at this point in treatment (last resort); at this point the attempts were probably futile after using untested ANZOR techniques and depleting any residual lung volume (relied upon by first aid measures, but depleted by these measures). The record shows that the first paramedic arrived on the scene at 3.43 pm (3.29 +14), however, the patient did not depart the scene until 4.16 pm (32 minutes scene time- maximum recommended ≤ 20 minutes) despite the hospital being only a 12-minute journey from the scene and 5 paramedics on scene. There are some significant questions to be answered by the Tasmanian Ambulance Service regarding response, training, conduct, and the priority management of patients in this case.

"The circumstances of Alby's death were extensively investigated by Uniform, Criminal Investigation Branch, and Forensic Services officers of Tasmania Police. No circumstances giving rise to any suspicion were identified. I am quite satisfied Alby's death was nothing other than an unimaginable tragedy."

The magistrate acting for the coroner in this case misunderstood the role of the task of the investigation as to be limited to determining suspicious vs. accidental cause. A formal inquest would surely have recognised the wider responsibility of the coroner (or a magistrate acting for the coroner) to look at the contributing factors, identify failures, and make recommendations to prevent a reoccurrence. Sadly, the magistrate in this case working outside a formal inquest procedure did

not, and thus had no lessons that may have been used to prevent future deaths. It is not clear, under Tasmanian law who decides as to whether to undertake a formal inquest or a non-inquest investigation, however in this case this was a significant and lasting mistake.

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

CORONERS ACT 1995 - SECT 28
Findings, of coroner investigating a death
(1) A coroner investigating a death must find, if possible –
(a) the identity of the deceased; and
(b) how death occurred; and
(c) the cause of death; and
(d) when and where death occurred; and
(e) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1999 .
(f) . . . . . .
(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.
(4) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.
(5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care.

The magistrate acting in this case has not acted in accordance with Section 28 of the Coroners Act 1995 as the Act does not make it unnecessary to "make any comments or recommendations". The magistrate in this matter has only complied with Sections 1, 4, and 5; and has not complied with the requirements of the case set out in Sections 2, and 3 i.e. mandated minimal requirements. If ever there was a case where there was an opportunity to make lasting and necessary changes to prevent this tragic incident from occurring in the future; it was this case. One could only conclude this to be faineance by the Tasmanian Coroners Office. The evidence in this case is that even full compliance with locally produced first aid measures makes no difference in cases of severe obstructions. LifeVac™ is used around the world (including every school in Northern Ireland) and has saved over 1100 children (out of over 1900 saves) after even the best first aid has failed and has never caused harm. All these case reports are part of an international multi-institutional study and usage is monitored by the regulators (in Australia the TGA) for failure or harm.

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