IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003101

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Ingrid Giles, Coroner
Deceased:	HMQ[1]
Date of birth:	[redacted] 2017
Date of death:	08 June 2022
Cause of death:	1(a) Aspiration pneumonia complicating a gastrointestinal illness in a child with cerebral palsy
Place of death:	[redacted] Victoria, [redacted]
Keywords:	ASPIRATION PNEUMONIA; CEREBRAL PALSY; CHILD DEATH; CHILD PROTECTION; NATURAL CAUSES

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased with a pseudonym of a randomly generated three letter sequence for the purposes of publication.

INTRODUCTION

1. HMQ was 5 years old when he died at home on 8 June 2022. At the time of his death, HMQ lived with his long-term foster mother and father, with whom he had lived for approximately four of his five years. HMQ also lived with his foster siblings.

2. HMQ was born premature and had a number of complex care needs. He had a genetic condition (CACNA1A deletion) which caused severe disability. He had cerebral palsy Gross Motor Function Classification System (GMFCS) level 5, which meant he was wheelchair-bound, non-verbal and dependent on others for his care. He was unable to take feeds orally and was at risk of aspiration pneumonia, hence had a gastrostomy tube for all feeds and medications. He had epilepsy with intractable seizures, kidney disease (renal tubular acidosis), metabolic bone disease resulting in spontaneous fractures and severe obstructive sleep apnoea. HMQ required 24-hour care and monitoring.

3. Child Protection became involved with HMQ on [redacted]2017 when he was two days old and still in the care of his birth parents. Following a second report being made to Child Protection on 10 March 2018, Child Protection issued a 'Protection Application by Emergency Care' and HMQ was ultimately placed with long-term foster parents.

4. HMQ was subsequently made subject to a Care by Secretary order on 24 October 2019. At the time of his death, there was an application before the Courts for a long-term care order with a plan for HMQ to remain placed with his foster parents until his eighteenth birthday.

5. HMQ's foster parents described him as a happy and smiling boy who they loved and adored. HMQ's foster mother stated they felt blessed to have him in their lives, although it was for far too short of a time.

THE CORONIAL INVESTIGATION

6. HMQ's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) on the basis that HMQ was 'person placed in care' under section 3(1) of the Act. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes.

7. There is also a requirement under section 52(2)(b) of the Act to hold an Inquest into the death of a person who was in custody or care immediately prior to passing, though pursuant to section 52(3A) of the Act, the coroner is not required to hold an Inquest if the coroner

considers the death was due to natural causes. I exercise my discretion under this provision not to hold an Inquest in the present case on the basis that HMQ's passing was due to natural causes and there are no further issues I have identified that require the hearing of *viva voce* evidence.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. Then-Deputy State Coroner Hawkins (**DSC Hawkins**) originally had carriage of this investigation. I took carriage of this matter on 27 October 2023 for the purposes of seeking further discrete advice from the Coroners Prevention Unit (**CPU**) to build upon advice already sought by DSC Hawkins,[2] finalising the investigation and making findings.

11. This finding draws on the totality of the coronial investigation into the death of HMQ including evidence obtained in the course of the investigation. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

[2] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. HMQ was at home with his parents and was unwell with vomiting and diarrhea from 6 June 2022. According to HMQ's foster mother, he would often have episodes of vomiting without any obvious cause.

13. At 7:00am on 8 June 2022, HMQ's foster father woke up and checked on HMQ. He was asleep. HMQ's foster mother checked on him at 7:20am and he was still asleep. She set up the baby monitor and started to assist the other children to get ready. She could hear HMQ breathing on the monitor.

14. HMQ's foster mother went in to see HMQ as he had woken up. She placed him on the bed to change his nappy and noticed his eyes were open but they were dazed. He appeared floppy, lethargic, and grey. She called her husband and asked if she should take HMQ to hospital. He advised her to call emergency services.

15. Ambulance Victoria paramedics attended the home and provided assistance. HMQ deteriorated and CPR was commenced, however he was unable to be revived and passed away at about 11:30am.

IDENTITY OF THE DECEASED

16. On 8 June 2022, HMQ, born [redacted] 2017, was visually identified by his foster father, who signed a formal statement of identification to this effect.

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

MEDICAL CAUSE OF DEATH

18. On 9 June 2022, Forensic Pathologist Dr Chong Zhou (**Dr Zhou**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination. Dr Zhou reviewed the Victoria Police Report of Death Form 83, Ambulance Victoria records, sudden unexpected death in infancy checklist, Department of Health and Human Services response to notification of child death, [redacted] Superclinic medical records, VIFM contact log, post-mortem radiology, the Royal Children's Hospital skeletal survey and whole-body CT scan report, Victorian Infectious Diseases Reference Laboratory COVID-19 report, VIFM toxicology report, and Melbourne Health Pathology vitreous biochemistry report and provided a written report of her findings.

19. Dr Zhou noted that HMQ had a history of quadriparetic cerebral palsy in which he was exclusively fed via a gastronomy tube for recurrent aspirations. His death was preceded by gastrointestinal symptoms including vomiting and diarrhoea.

20. The external examination was consistent with the reported circumstances and did not show any significant injuries that may have caused or contributed to death.

21. The post-mortem CT scan showed increased lung markings within the bilateral lower lobes and patchy foci of consolidation within the left lower lobe. These features would be in keeping with aspiration pneumonia. The PEG tube was correctly sited without complications, and the bowels appeared unremarkable. There was no evidence of skeletal trauma.

22. Dr Zhou opined that it is likely that the deceased had a gastrointestinal illness involving vomiting, which was subsequently complicated by aspiration pneumonia as the deceased was at high risk of aspiration.

23. Aspiration pneumonia is an inflammatory and infective process within the lungs that occurs after inhaling (aspirating) foreign material, such as food or vomitus, which enables the entry of bacteria into the lungs. Aspiration pneumonia can progress to sepsis, respiratory failure, and death.

24. The deceased had a history of epilepsy, however, there was no reported seizure activity prior to death. It is well recognised that epilepsy predisposes an individual to a higher risk of sudden death (Sudden Unexpected Death in Epilepsy, SUDEP), which is thought to be mediated through neuro-cardiac and neuro-respiratory pathways.

25. Toxicological analysis of post-mortem samples showed non-toxic levels of HMQ's prescribed medications.

26. Vitreous humour biochemistry showed dehydration without significant renal impairment.

27. Dr Zhou provided an opinion that the medical cause of death was *1 (a) aspiration pneumonia complicating a gastrointestinal illness in a child with cerebral palsy*. Dr Zhou was of the opinion that HMQ's death was due to natural causes.

28. I accept Dr Zhou's opinion.

REVIEW OF CARE

29. Given the circumstances of HMQ's death and the fact he was 'in care' immediately prior to passing, additional statements were sought from the Department of Families, Fairness, and Housing (**the Department**) and Monash Health regarding the care and support provided to HMQ and his family.

Monash Health

30. Consultant General Paediatrician, Dr Catherine McAdam provided a statement to the Court in relation to the care provided to HMQ from 2018 up until the time of death. Dr McAdam was the lead general paediatrician for HMQ.

Diagnosis and conditions

31. Dr McAdam provided a summary of HMQ's medical conditions and diagnoses. He was born prematurely and small for gestational age. Subsequent investigations found him to have a genetic condition with CACNA1A deletion which causes severe disability.

32. He had cerebral palsy with GMFCS-level 5, meaning he was wheelchair bound and dependent on others for his care. He was unable to speak but communicated by sounds, facial expression, and eye contact.

33. HMQ had intractable epilepsy despite anticonvulsant therapies. He had a combination of generalised tonic clonic seizures and absence seizure. He had been admitted to the Paediatric Intensive Care Unit (**PICU**) with prolonged seizures (status epilepticus) on two previous occasions. His seizures came under better control when placed on a ketogenic diet.

34. HMQ was unable to take feeds orally but was able to swallow his own saliva. He had a gastrostomy for all feeds and medications. He sometimes vomited, especially when unwell and was at risk of aspiration pneumonia. Whilst in the care of his foster parents, although HMQ was known to be at risk of aspiration pneumonia and the diagnosis previously considered when he had respiratory infections, he had never had a confirmed episode of aspiration pneumonia.

35. He had a renal tubular acidosis of unclear cause which was discovered during the admission in April 2020. This may have been due to the ketogenic diet as no other underlying cause was found. As the diet was the only way to control his seizures and ensure good quality of life, he

was managed with supplements making a complex feeding and medication regimen for his carers to follow.

36. HMQ had metabolic bone disease leading to spontaneous femur fractures. This was due to a combination of the ketogenic diet, antiepileptic medications, the renal tubular acidosis and his cerebral palsy where he was not able to weight bear. He was treated with bisphosphonate infusions every six months to reduce the risk of further pathological fractures.

37. He was diagnosed with severe obstructive sleep apnoea in mid-2022. Dr McAdam was concerned by this and an identified increase in HMQ's spasticity. She arranged high priority referrals to the Monash Children's sleep clinic to review the obstructive sleep apnoea symptoms. Dr McAdams encouraged contact from HMQ's foster mother to monitor his condition. She did not think a hospital admission was required urgently at this time. HMQ was determined to require urgent category 1 tonsillectomy, adenoidectomy, and examination under anaesthetic of his ears. This was scheduled for June 2022 but did not occur prior to HMQ's death.

Prognosis

38. Dr McAdams stated that HMQ had a very complex and fragile medical status with a high risk of premature death due to his severe degree of disability, combined with the unpredictable nature of his seizures. He required 24-hour care, with no expected improvement in the future. He was considered to be at high risk of aspiration, especially as he often vomited when unwell.

39. Dr McAdams described his prognosis as "guarded". In April 2022, she advised the Department:

> "There is no specific life expectancy associated with his condition but people with a diagnosis of severe cerebral palsy and seizure disorder like HMQ are considered at high risk of premature death".

40. Dr McAdams advised that in discussion with HMQ's foster parents, they always prioritised HMQ's comfort and participation in community activities.

April-May 2022 admission

41. HMQ was admitted to Monash Children's Hospital on 30 April 2022 due to increased seizures and difficulty breathing. He was diagnosed with community acquired pneumonia, in the setting of a viral illness. The possibility of aspiration pneumonia was considered at that time. He required respiratory support with high flow nasal prong oxygen. HMQ was reviewed by

the registrar due to concern about central and obstructive apnoea, as well as the degree of respiratory distress he exhibited. He settled sufficiently and was admitted to the ward.

42. HMQ was treated with IV antibiotics as per the guidelines for severe pneumonia. He was referred to the Respiratory and Sleep unit due to concerns around obstructive sleep apnoea. They recommended testing when he had recovered from his acute illness.

43. During his admission, HMQ had purulent eye discharge and was treated for bacterial conjunctivitis with chloramphenicol eye drops and ointment. He developed vomiting and diarrhoea and his feeds were slowed and changed to PEG feeds. The diarrhoea was considered to be due to the antibiotics. He improved over the next few days and no longer required respiratory support. He was changed to PEG antibiotics with a plan to complete five days of antibiotic treatment.

44. HMQ's seizure frequency and focal seizures increased during this presentation. His seizure threshold was felt to be lowered due to fever and a change in his ketogenic feeding regimen. He had a loading dose of levetiracetam and increase in clonazepam drops after consultation with the neurology team. His seizures returned to baseline.

45. HMQ required supplemental oxygen from admission to 2 May 2022 when he was weaned down to room air. He had intermittent episodes of obstruction, which were thought to represent his underlying obstructive sleep apnoea for which an investigation and management plan was in place.

46. HMQ was transferred home on 5 May 2022. Discharge criteria were met and a medical treatment plan was put in place, as well as regular follow up with Monash Health and HMQ's GP. Follow up on 6 and 7 May 2023 confirmed gradual resolution of the diarrhoea, reduced vomits, normal vital signs, and adequate hydration. HMQ was smiling and becoming more interactive. He was considered to be slowly improving after the admission for pneumonia.

47. Dr McAdams noted that HMQ's foster mother had a written plan for how to manage his feeds and monitoring blood levels. She was an experienced mother and would adjust medications and feeds within parameters suggested by medical and nursing staff, in the knowledge that telephone and email advice could be provided. HMQ was able to be cared for at home and his

usual clinical teams were able to direct care instead of new doctors who had not met him before.

Department of Families, Fairness and Housing

48. An advanced Child Protection Practitioner from the Department provided a statement in relation to the Department's involvement and care of HMQ.

49. As noted earlier, HMQ was subject to two reports made to Child Protection between [redacted] 2017 and 25 July 2022. At the time of his death, HMQ was under the care of the Department and was subject to a Care by Secretary Order on 24 October 2019. HMQ's permanency objective under section 166 of the *Children, Youth and Families Act 2005* was for long-term out of home care. This was determined to be required in order to meet HMQ's complex medical needs.

50. The Department advised that HMQ was supported by a multi-disciplinary team consisting of a paediatrician, Monash Health Complex Care, a neurologist, occupational therapists, physiotherapists, sleep specialist, and Vision Australia. HMQ also had a National Disability Insurance Scheme (**NDIS**) plan in place. He was enrolled in a local kindergarten program two days per week for 3-4 hours a day by his foster parents.

51. Child Protection made an application for a long-term care order on 29 October 2021, however this was not finalised before HMQ's death. This was considered appropriate as HMQ's foster parents were committed to continue caring for HMQ but were not seeking permanent care as they required continued support from OzChild and Child Protection, given the complexities of HMQ's needs.

Concerns of carers

52. Correspondence was received from HMQ's foster parents in July and October 2022 seeking clarification, *inter alia*, as to the reasons for the rapidity of HMQ's deterioration after becoming unwell on 6 June 2022 and whether they had done all they could for him, noting that *'[h]e had had so many other vomiting incidents before that over the past four years, which looked exactly the same as the two days before he passed*.'

53. Having sought advice in early 2024 from the CPU regarding these concerns in the interests of completeness, I am advised, and so find, that the care provided to HMQ by his foster parents was comprehensive and that the course adopted for his illness that started on 6 June 2022 was

reasonable, given that HMQ had had multiple episodes of similar vomiting in the past and that it had been a relatively short period of him being unwell. I note further the comments made by Dr McAdams that his prognosis was "guarded" and of Dr Zhou that his passing was due to natural causes.

54. The evidence shows HMQ being well-cared for by his foster parents, who dedicated their love, energy and deep parenting experience to care for a very ill young boy for the vast majority of his life, and in circumstances where his biological parents were unable to provide such care.

Discussion

55. Having further reviewed the statements and material provided by Monash Health and the Department, and in line with advice provided by the CPU when former DSC Hawkins had carriage of the matter, I consider that the care and treatment provided to HMQ was appropriate. The statements provided were thorough and demonstrate sound practice.

56. In particular, I consider that the medical care provided by Monash Health was comprehensive and appropriate. HMQ was a very unwell young boy with a guarded prognosis. He was reported to be at high risk of premature death.

FINDINGS AND CONCLUSION

57. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was HMQ, born [redacted] 2017;

    b) the death occurred on 08 June 2022 at [redacted] Victoria, [redacted], from aspiration pneumonia complicating a gastrointestinal illness in a child with cerebral palsy; and

    c) the death occurred in the circumstances described above.

58. Having considered all of the circumstances, I find that HMQ's death was due to natural causes. I have not identified any prevention opportunities.

59. I convey my sincere condolences to HMQ's loved ones for their loss.

ORDERS

60. Pursuant to section 73(1B) of the Act, I order that this finding be published (in redacted form) on the Coroners Court of Victoria website in accordance with the rules.

61. I direct that an unredacted copy of this finding be provided to the following:

HMQ's foster parents, Senior Next of Kin

Peter Ryan, Monash Health

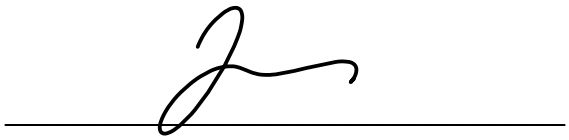
Colleen Carey, Department of Families, Fairness and Housing

Commission for Children and Young People

Senior Constable Talissa Croxford, Coroner's Investigator

Victorian Institute of Forensic Medicine

Signature:



Date : 24 January 2024

*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.*