IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 0288

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of BABY MINAHIL BHATTI

without holding an inquest pursuant to section 52(3A) of the *Coroners Act 2008*:
find that the identity of the deceased was BABY MINAHIL BHATTI
born 15 March 2016
and the death occurred on 26 August 2016
at the Royal Children's Hospital, 50 Flemington Road, Parkville Victoria 3052
from:

1 (a) SEPTIC SHOCK WITH MULTI-ORGAN FAILURE AND PROBABLE MENINGITIS

1 (b) NON-COMPACTION CARDIOMYOPATHY

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Baby Minahil Bhatti was five months old when she died on 26 August 2016 at the Royal Children's Hospital (**RCH**).

2. The Court received a delayed notification of Baby Minahil's death from the Department of Health and Human Services (**DHHS**) in January 2017. Following receipt of this notification, I directed that further information be sought from the DHHS. On 13 July 2017, the Court received a statement from Eddy De Nardis, Area Manager, Child Protection, Western Melbourne Area, West Division, DHHS.

3. Baby Minahil was born at term on 15 March 2016, at the Royal Women's Hospital. While in-utero, Baby Minahil was diagnosed with left renal abnormalities, and was referred to the Royal Children's Hospital renal clinic for follow up.

4. On 31 March 2016, Child Protection received a report, which indicated concerns related to Baby Minahil's poor weight gain, ill-health and parenting issues. Baby Minahil was classified as a High Risk Infant.

5. On 2 April 2016, a Protection Application was issued for Baby Minahil at the Children's Court in Melbourne. Baby Minahil was subsequently placed on an Interim Accommodation Order, with a condition that she stay at the RCH. On 6 April 2016, Baby Minahil was discharged from hospital to the care of her parents.

6. On 12 May 2016, a 12 month Family Preservation Order was issued in the Children's Court in Melbourne. Baby Minahil was placed in the care of her parents, and the Order contained 12 conditions.

7. Baby Minahil's parents brought her to the RCH on 27 July 2016, after two days of lethargy, sweating, increased work of breathing and poor feeding. She was diagnosed with left ventricular non-compaction cardiomyopathy with severe left ventricular dysfunction. Baby Minahil was admitted to the Intensive Care Unit (**ICU**) from 27 July 2016, to 1 August 2016. She was subsequently transferred to a ward. On 19 August 2016, Baby Minahil's condition deteriorated significantly, with fever, seizures and haemodynamic instability. She was returned to the ICU and sepsis was suspected, with meningitis a likely source. All cultures taken were negative. Baby Minahil was treated with six days of antibiotics and increasing inotropic support. She continued to deteriorate and developed multi-organ failure and haemodynamic instability.

8. On 25 August 2016, Child Protection was advised that Baby Minahil's condition had deteriorated significantly and her prognosis was poor. After discussion with Baby Minahil's family, a decision was made to focus on comfort care. On 26 August 2016, Baby Minahil was declared deceased.

9. Baby Minahil's death was considered reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act') because at the time of her death, she was subject to a Family Preservation Order, and considered to have been a person placed in care. Pursuant to section 3 of the Act, a person placed in care includes a person who is under the control, care or custody of the DHHS.

INVESTIGATIONS

The medical cause of Baby Minahil's death

10. I directed that the Court obtain Baby Minahil's Medical Certificate of Cause of Death, from Births, Deaths and Marriages Victoria. This document indicated that Baby Minahil died of septic

shock with multi-organ failure (culture negative), and probable meningitis. An antecedent cause of Baby Minahil's death was considered to be non-compaction cardiomyopathy.

11. In his statement, Mr De Nardis advised that Baby Minahil was referred to the Victoria Forensic Paediatric Medical Service for a forensic assessment. It was confirmed that Baby Minahil's heart condition, cardiomyopathy, was not caused by any medical neglect as she was born with this condition.

Coroners Prevention Unit review

12. I asked the Coroners Prevention Unit (CPU)[1] to review Baby Minahil's medical records, and provide advice as to whether she died from natural causes. The review confirmed that Baby Minahil's death appeared to be from natural causes, and was unrelated to the care she received at home, or the oversight by Child Protection.

13. In particular, the medical records did not suggest there was any need for earlier medical intervention regarding Baby Minahil's cardiac disease. It was identified that Baby Minahil's mother appropriately brought her to the RCH when she became acutely unwell with cardiac failure on 27 July 2016. Prior to this presentation, there were no significant signs or symptoms to indicate serious cardiac disease. While a chest x-ray may have detected Baby Minahil's cardiac condition earlier, there was nothing to indicate cardiac disease on her prior presentations to the RCH; it was considered reasonable that an x-ray was not performed. While non-compaction cardiomyopathy is congenital, it can present at any age. The review identified that had Baby Minahil been diagnosed earlier, this may not have changed the final outcome, as the condition has a high incidence of heart failure, sudden cardiac death and systemic embolic events.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. Section 52 of the Act mandates the holding of an Inquest if the deceased was, immediately before death, a person placed in care, save for circumstances where the person is deemed to have died from natural causes, pursuant to section 52(3A). In the absence of any nexus between Baby

[1] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

Minahil's care and her cardiac condition, and noting from the death certificate, Mr De Nardis' evidence and the CPU review that the medical cause of Baby Minahil's death appears to have been from natural causes, I have determined, pursuant to section 52(3A), that an Inquest is not required.

FINDINGS

The evidence indicates that Baby Minahil suffered from a congenital cardiac condition, which was only diagnosed in the last month of her life. On the evidence available to me, I find that the oversight by Child Protection was reasonable, and that the care Baby Minahil received did not cause or contribute to her death.

I accept and adopt the medical cause of death as detailed on the Medical Certificate of Cause of Death, and find that Baby Minahil Bhatti tragically died from natural causes, being septic shock with multi-organ failure and probable meningitis, secondary to non-compaction cardiomyopathy.

Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

The parents of Baby Minahil Bhatti
Office of Professional Practice (Child Death Inquiries), Department of Health and Human Services
Ms Emma Carnovale, General Counsel, Royal Children's Hospital
Principal Commissioner, Commission for Children and Young People
Consultative Council on Obstetric and Paediatric Mortality and Morbidity
Leading Senior Constable Kelly Ramsey

Signature:

AUDREY JAMIESON
CORONER

Date: **11 September 2017**