IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 5435 / 2012

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: LUKE HYATT

Delivered On:	16 December 2012
Delivered At:	Melbourne Coroners Court 222 Exhibition Street, Melbourne
Hearing Dates:	16 December 2012
Findings of:	IAIN WEST, DEPUTY STATE CORONER
Representation:	No appearance
Police Coronial Support Unit	Sergeant Greig McFarlane

I, IAIN WEST, Deputy State Coroner having investigated the death of Luke Hyatt

AND having held an inquest in relation to this death on 16 December 2013

at Melbourne Coroners Court, 222 Exhibition Street, Melbourne

find that the identity of the deceased was Luke Andrew Hyatt

born on 1 February 2006

and the death occurred on 21 December 2012

at the Royal Children's Hospital, Parkville

from:

1 (a) Acute on chronic respiratory failure in the setting of hypotonic quadriplegic cerebral palsy

in the following circumstances:

1. Luke was aged 6 years at the time of his death and was placed in Foster Care by the Department of Human Services Child Protection from age thirteen months. He lived with his foster carers, Robert and Barbara Patterson at 38 Station Street, Melton South. Luke had a long medical history including severe cerebral palsy quadriplegia, chronic lung disease, a heart block requiring a pacemaker and other medical problems. He had multiple admissions throughout his short life to the Royal Children's Hospital.

2. On the 25 November 2012, Luke was admitted to hospital suffering from a respiratory infection and on the 2 December, was transferred to the Intensive Care Unit where he was commenced on non invasive ventilatory support. On the 3 December his condition deteriorated further such that he required intubation and ventilation. Despite extremely high levels of ventilation to maintain his oxygen saturations, Luke's condition continued to deteriorate, resulting in numerous discussions between his medical carers, foster family, biological mother and Department of Human Services representatives. These discussions centred around Luke's extremely grave prognosis and culminated in the decision being made to withdraw mechanical ventilation in conjunction with active care to ensure Luke remained comfortable and un-distressed. Luke died at approximately 4.00pm on the 21 December 2012.

3. No autopsy was performed in this case, as the coroner, following consultation with Dr Yeliena Baber, Forensic Pathologist with the Victorian Institute of Forensic Medicine, directed that no autopsy was required. Dr Baber performed an external examination of Luke at the mortuary, reviewed the circumstances of his death, the medical deposition and clinical notes, the post mortem CT scan and provided a written report of her findings. She reported that in all the circumstances a reasonable cause of death was acute on chronic respiratory failure in the setting of hypotonic quadriplegic cerebral palsy.

4. I formally find that Luke Hyatt died from acute on chronic respiratory failure in the setting of hypotonic quadriplegic cerebral palsy.

COMMENTS

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

5. I further find that Luke's care whilst a client of the Department of Human Service was appropriate and that his care and treatment at the Royal Children's Hospital was within the parameters of reasonable health care management.

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

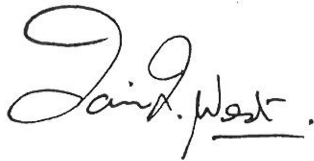
Luke's mother, Nicole Hyatt

Luke's foster carers, Barbara and Robert Patterson

Medical Director, Royal Children's Hospital

Michelle Kontesis, Department of Human Services

Signature:



IAIN WEST
DEPUTY STATE CORONER
Date: **16 December 2013**