Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court Reference: 5366/09

Inquest into the Death of Mykayla Chloe Marshall

Delivered On:

6th April 2011

Delivered At:

Latrobe Valley Coroners Court

Hearing Dates:

6th April 2011

Findings of:

F A Hayes

Place of death/Suspected death:

Main Road, Willow Grove

Counsel Assisting the Coroner

Senior Constable Gibbons

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court Reference: 5366/09

In the Coroners Court of Victoria at Morwell

IF A Hayes, Coroner having investigated the death of:

Details of deceased:

Surname:

Marshall

First name:

Mykayla Chloe

Address:

1151 Main Road Willow Grove VIC 3825

AND having held an inquest in relation to this death on 6th April 2011

at Latrobe Valley Coroners Court

find that the identity of the deceased was Mykayla Chloe Marshall and death occurred on 13th November 2009

at Main Road Willow Grove

from

- 1a Pulmonary hypertension and right heart failure
- 1b Total anomalous pulmonary venous drainage (operated)
- 1c Pulmonary vein stenosis (operated)
- 1d Atrial and ventricular septal defects (repaired)

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in the following circumstances:

Mykayla Marshall was aged 15 months when on 13 November 2009 she died at her family home. Mykayla was a much loved little girl, who is greatly missed by her family, including her sister Angel and her twin sister, Matilda.

This inquest is conducted pursuant to section 52(2)(b) of the Coroners Act 2008, as Mykayla was, at the time of her death, subject to a Custody to Secretary Order, under the Children Youth and Families Act, and therefore, immediately before death, a person placed in custody or care.

Pursuant to that order, Mykayla resided with her maternal Aunt, Tammy Locke and her partner Glen Smith, her older sister Angel and her twin sister Matilda.

Mykayla and Matilda were born on 28 July 2008 at the Latrobe Regional Hospital. Mykayla was born with a complex congenital cardiac abnormality, which required surgery within the first day after birth.

Mykayla was treated by a number of specialist medical practitioners, including Dr Gemma Crighton at the Royal Children's Hospital and Dr Sari Hayllar of the West Gippsland Paediatric Group.

Dr Crighton provided a statement, which set out the conditions which Mykayla lived with, which are as follows:

- Total anomalous pulmonary venous drainage supracardiac, atrial septal defect and patent ductus arteriosus (repaired one day of life);
- Pulmonary hypertension secondary to left pulmonary vein stenosis;
- Chronic heart failure secondary to pulmonary hypertension;
- Born at 36 weeks, one of twins;
- Global developmental delay (neonatal encephalopathy);
- Chronic lung disease;
- Gastro-oesophageal reflux disease.

Dr Crighton treated Mykayla from 13 August 2010 onwards. She stated that on 13 November 2010 she received a call from Tammy Locke. Dr Crighton stated that Tammy said that she thought Mykayla was deteriorating and that she may be dying. Dr Crighton worked over the phone to assist Ms Locke in administering appropriate medication to Mykayla. Less than 10 minutes later, Ms Locke advised Dr Crighton that Mykayla had stopped breathing. An ambulance was called and Ms Locke performed CPR. Ambulance officers attended but despite all of their efforts, Mykayla could not be resuscitated.

Dr Hayllar stated that "in the last weeks of her life Mykayla's medical condition was very precarious requiring strict attention to fluid intake, regular giving of medications, daily or twice weighs, strict fluid balance to be recorded including oral intake of water and weight of nappies and a record of her vital signs(heart rate, respiratory rate, temperature and oxygen saturation). All of this care was given by Tammy with the support of Glenn in an extremely careful and methodical manner." Dr Hallyar saw Mykayla two days before she died and stated at "her worsening state was apparent" and that "despite the most innovative medications available Mykayla ultimately succumbed with worsening heart failure." She also stated "It was a pleasure to meet this brave little girl and the carers who supported her so conscientiously and courageously."

A post-mortem examination was performed by Dr Duncan MacGregor, Paediatric Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr MacGregor formulated the cause of Mykayla's death as;

- 1(a) Pulmonary hypertension and right heart failure
- 1(b) Total anomalous pulmonary venous drainage (operated);
- 1(c) Pulmonary vein stenosis (operated)
- 1(d) Atrial and ventricular septal defects (repaired).

On the basis of the examination, I find that Mykayla died of natural causes.

However, I want to acknowledge the significant care and support given to Mykayla by Tammy Locke and Glen Smith. Their commitment to Mykayla's quality of life and to helping her manage her significant health issues at home is a great credit to them. I extend my condolences to all members of Mykayla's family.

Signature:

Date: 6 / 4 / 201