IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5842

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**SIMON McGREGOR, CORONER**
Deceased:	**BABY L**
Date of birth:	11 November 2017
Date of death:	18 November 2017
Cause of death:	1(a) OEIS Complex (Omphalocoele, Exstrophy of Cloaca, Imperforate Anus, Spinal Defects) and prematurity.
Place of death:	Royal Children's Hospital, 50 Flemington Road, Flemington, Victoria

TABLE OF CONTENTS

HIS HONOUR:

BACKGROUND

1. Baby L was seven days old at the time of her death. She was the child of Ms M and Mr N. Baby L was the eighth child of the relationship.

2. Ms M and Mr N's seven other children are each subject to Care by Secretary Orders and the older children have been the subject of Protections Orders in various forms since 2004.

3. There was no current plan for reunification at the time of writing in light of unresolved protective concerns in relation to each parent. The available evidence suggests that Ms M and Mr Nexperience a multitude of complex issues, such as traumatic histories, mental health issues, substance issues and family violence.

4. The available evidence suggests that Ms M received minimal prenatal care during her pregnancy with Baby L. Medical records suggest that late in the pregnancy, on 27 October 2017, ultrasound imaging revealed multiple abnormalities in the foetus.

5. Significant concerns had been raised for both mother and baby's safety and well-being throughout Ms M's pregnancy which led to Child Protection (**CP**) being notified when Ms M presented at Echuca Hospital in premature labour at 32 weeks gestation.

6. Baby L was born on 11 November 2017.

7. A Protection Order was served by CP upon Ms M on 14 November 2017 and on 15 November 2017 the Bendigo Childrens' Court granted an Interim Accommodation Order (**IAO**) for Baby L's hospital placement until 6 December 2017.

THE PURPOSE OF A CORONIAL INVESTIGATION

8. Baby L's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and at the time of death she had been the subject of a Protection Order placing Baby L under the care of the Department of Health and Human Services (**DHHS**).[1]

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the

[1] Section 4 *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*

identity of the deceased person, the cause of death and the circumstances in which death occurred.

10. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

11. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

12. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

13. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

14. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] 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 that they caused or contributed to the death.

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[3] *Keown v Khan* (1999) 1 VR 69.
[4] (1938) 60 CLR 336.

16. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

MATTERS IN RELATION TO WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

17. On 18 November 2017, Ms M identified the deceased, to be Baby L, born 11 November 2017.

18. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

19. On 20 November 2017, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination of the deceased's body. Dr Lynch provided an original report dated 27 November 2017; then a supplementary written report, dated 15 April 2019 which ultimately concluded that the deceased died from *"1(a) OEIS Complex (Omphalocoele, Exstrophy of Cloaca, imperforate Anus, Spinal Defects) and Prematurity."*

20. I accept the cause of death proposed by Dr Lynch.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

21. Baby L was born on 11 November 2017 at the Royal Womens' Hospital at 32 weeks gestation, weighing 1745 grams.

22. Baby L was born with multiple congenital defects, including omphalocoele,[5] exstrophy of the cloaca (exposed bladder and intestines), imperforate anus (a malformed rectum) and spinal defects, considered not amenable to surgical intervention.

23. In the days after her birth, Baby L required *"maximal levels of intensive care support"*[6] including being dependent on mechanical ventilation for survival and had complex renal and biochemical needs. The neonatologist involved in Baby L's care, Dr David Tingay, noted:

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[5] A hernia in which abdominal organs protrude into the baby's umbilical cord.
[6] Statement of Dr David Tingay, dated 27 February 2018.

"The omp[halocoele] and exstrophy of the cloacae created a large abdominal wall defect. Unrepaired the defect is lethal due to high insensible fluid losses, impaired renal, intestinal failure and sepsis. During my consultations with Mr O'Brien and A/Prof King I was informed that the defect was too large to allow adequate surgical closure. In addition, even if surgical closure were possible, reconstructive surgery would not be able to achieve urinary or faecal continence."[7]

24. On 16 November 2017 CP was contacted by the Royal Children's Hospital informing them of the medical team's decision that nothing further could be done to correct Baby L's condition and that palliative care would be recommended.

25. Treatment was withdrawn from Baby L on 18 November 2017 and she died at 2:12pm that day in the presence of her parents and other family members.

26. In his statement, Dr Peter Jurcevic,[8] confirmed that despite Ms M's long-term substance abuse and diabetes:

"[I]t is unlikely that this contributed to the significant abnormalities that the baby endured...The fetal anomalies were almost certainly random in nature."[9]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

27. In the course of my investigation I did not identify any prevention matters arising from the circumstances of Baby L's death.

FINDINGS AND CONCLUSION

28. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was Baby L, born 11 November 2017;

    (b) the death occurred on 18 November 2017 at the Royal Children's Hospital, Victoria, from *OEIS Complex (Omphalocoele, Exstrophy of Cloaca, Imperforate Anus, Spinal Defects) and prematurity*; and

    (c) the death occurred in the circumstances described above.

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[7] Ibid, 7.
[8] Senior Consultant and Director of Blue Team Obstetrics at the Royal Womens' Hospital, statement dated 9 August 2018.
[9] Statement of Dr Peter Antony Jurcevic, dated 9 August 2018.

29. I convey my sincerest sympathy to Baby L's parents and family.

30. I direct that this Finding be published on the internet, with the deceased and her family referred to by pseudonyms.

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

    (a) Senior Next of Kin;

    (b) Ms Majella Foster-Jones, Victoria Legal Aid, interested party

    (c) Ms Liana Buchanan, Principal Commissioner, Commission for Children and Young People, interested party;

    (d) Ms Emma Carnovale, General Counsel, Royal Children's Hospital, interested party; and

    (e) Senior Constable Carlie DeBono, Victoria Police, Coroner's Investigator.

Signature:

SIMON McGREGOR
CORONER
Date: 17 June 2019