IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 4465

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Simon McGregor, Coroner
Deceased:	HJ
Date of birth:	13 June 2014
Date of death:	22 August 2019
Cause of death:	**1(a) Acute obstructive hydrocephalus complicating meningoencephalitis in the setting of previous left hemispherectomy for left hemispheric cortical malformation (FCD-2A)**
Place of death:	Monash Children's Hospital 246 Clayton Road, Clayton, Victoria

HIS HONOUR:

THE CORONIAL INVESTIGATION

1. HJ was a five-year-old who lived in Skye at the time of his death. He had a complex medical history from shortly after his birth, and had a cardiac arrest at home on 20 August 2019. He did not recover from the brain injuries suffered during this arrest and was declared deceased in hospital on 22 August 2019.

2. HJ was the subject of a long-term care order under the *Children, Youth and Families Act 2005* (Vic), conferring parental responsibility on the Secretary of the Department of Health and Human Services (**DHHS**).[1]

3. HJ was therefore a '*person placed in custody or care*' for the purposes of the *Coroners Act 2008* (Vic) (**the Act**), and his death was then a '*reportable death*' for the purposes of the Act.[2]

4. 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.

5. 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.

6. The Coroner's Investigator, First Constable Rachel Crocker, prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians and investigating officers.

7. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

---

[1] *Children, Youth and Families Act 2005* s 290(1)(a).
[2] *Coroners Act 2008* s 4(2)(c).

8. I have based this finding on these materials. In the coronial jurisdiction facts must be established on the balance of probabilities.[3] 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.

9. In considering the issues associated with this finding, I have been mindful of HJ's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. Shortly after his birth, the Secretary for the Department of Health and Human Services placed HJ in the care of his aunt, NC, and his maternal grandparents CC and PC for his own protection. They oversaw supervised visits by HJ's mother and father. HJ suffered a number of medical issues, including cerebral palsy which required the use of a wheelchair.[4]

11. Around a week after he was born, HJ began to suffer seizures and was admitted to the Royal Children's Hospital. An MRI of his brain found that he had extensive left-sided brain malformation. Although genetic testing was performed, no cause was ever found.[5]

12. Despite treatment with medication, HJ's seizures became worse the following February. An EEG showed a more serious pattern of epilepsy with the right side involved, and a repeat MRI found that spinal fluid was trapped, causing a build-up of fluid and pressure on the brain. On 15 May 2015 HJ had a left functional hemispherectomy, disconnecting the outer part of the left half of the brain from the right half to prevent the spreading of seizures.[6]

13. HJ initially required a nasogastric tube for food, and in January 2017 he had a percutaneous gastrostomy (**PEG**) tube inserted.[7]

14. HJ continued to be monitored medically, with a focus on global developmental delay, repetitive and anxious behaviours, poor sleep and sensory issues. In April 2019 he had a suspected absence seizure while at kindergarten, and an EEG was conducted on 14 May 2019.

---

[3] This is 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.

[4] Statement of NC; Statement of CC; Statement of PC; OzChild Report.

[5] Statement of Dr Monica Cooper.

[6] Statement of Dr Monica Cooper.

[7] Statement of Dr Monica Cooper.

This showed an abnormality on both sides, but as HJ had not had any known convulsive seizures, his medical staff decided to monitor his condition without taking immediate action.[8]

15. On 2 June 2019 HJ fell out of bed after what appeared to be myoclonus. He was then sleepy, lethargic, and frequently vomited. A CT brain scan was performed which was similar to the 2017 scan, showing hydrocephalus. The fluid-filled cavities looked to be the same size as on previous imaging, although there were some changes visible. The hydrocephalus did not appear to be causing problems, and it was expected that HJ's brain would grow more and that he would need a shunt. A plan was made to await a pre-booked MRI in five months' time.[9]

16. On the morning of 19 August 2019, HJ was bright and happy, and NC took him to day-care. However, at around 11.00am, the day-care centre called NC to tell her that HJ was lethargic and not himself. She went to pick him up, and he told her that he was tired and wanted to go home, so she brought him home.[10]

17. When he came home, he vomited. Over the rest of the day, he rested and was kept topped up with formula and water.[11]

18. HJ was still sleepy the next morning. However, around 10.00am, NC noticed that HJ had a temperature and that his breath seemed laboured. She immediately contacted emergency services.[12]

19. While she was on the phone, HJ's breathing stopped, and shortly afterward NC was unable to feel a pulse. NC began resuscitation attempts until paramedics arrived, who took over and were eventually able to restore his pulse. They transported HJ to the Emergency Department (**ED**) at the Monash Children's Hospital.[13]

20. Soon after arrived, HJ was taken to the Paediatric Intensive Care Unit where he had very concerning neurological signs, with absence of brainstem reflexes. CT brain imaging showed signs of significant brain injury from impaired blood flow and oxygen injury due to the cardiac arrest HJ had suffered at home.[14]

---

[8] Statement of Dr Monica Cooper.
[9] Statement of Dr Monica Cooper.
[10] Statement of NC.
[11] Statement of NC.
[12] Statement of NC.
[13] Statement of NC; Statement of Dr Kirsten Bakyew.
[14] Statement of Dr Kirsten Bakyew.

21. A formal CT report indicated raised intracranial pressure with obstructive hydrocephalus. Medical management for the intracranial pressure immediately commenced, and further specialists were consulted. Unfortunately, after review by the Neurosurgical Registrar, it was determined that there was a poor neurological prognosis and that there was no role for surgical intervention.[15]

22. Despite further intensive care treatment, HJ's condition worsened. After family meetings, it was agreed that HJ's brain was no longer functioning and that his condition as not compatible with life. He was declared wholly deceased by brain death at 12.10pm on 22 August 2020. With the family's consent, HJ donated organs through Donatelife before life support was removed.[16]

Identity of the deceased

23. On 22 August 2019, NC visually identified HJ Hogan, born 13 June 2014.

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

Medical cause of death

25. Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine **(VIFM)**, conducted an autopsy on HJ and provided a written report of her findings.

26. Examination of the brain found foci of infarction associated with secondary hypoxic ischaemic change, but also found foci of inflammation within the brainstem, cerebellum and cortex which did not have a typical hypoxic ischaemic performance. This was particularly notable in the cerebellar hemisphere and in meningeal tissue around the pituitary gland.

27. Dr Iles advised that this suggested a primary inflammatory process precipitating brain swelling, cardiorespiratory arrest and subsequent hypoxic ischaemic injury. She considered that such a meningoencephalic process is likely due to central nervous system infection, more likely bacterial than viral.

28. Virological studies performed on cerebrospinal fluid did not identify any viral pathogen. There was also no bacterial growth identified, but Dr Iles noted that HJ had been treated with antibiotics before his death.

[15] Statement of Dr Kirsten Bakyew.
[16] Statement of Dr Kirsten Bakyew.

29. Dr Iles also noted an unexpected finding at autopsy: the presence of serositis around the appendix associated with a small amount of refractile foreign material, with no pictures to suggest primary appendicitis. She considered that the most likely cause of this was a perforation or leak related to HJ's PEG tube. Dr Iles advised that the significance of this finding was unclear.

30. Dr Iles concluded that a reasonable cause of death was:

> **1(a) Acute obstructive hydrocephalus complicating meningoencephalitis in the setting of previous left hemispherectomy for left hemispheric cortical malformation (FCD-2A)**

31. She advised that, on the basis of the information available to her, she was of the opinion that the death was due to natural causes.

32. I accept Dr Iles' conclusions as to cause of death.

FINDINGS AND CONCLUSION

33. Pursuant to section 67(1) of the Act I make the following findings;

    (a) the identity of the deceased was HJ, born 13 June 2014;

    (b) the death occurred on 22 August 2019 at the Monash Children's Hospital, 246 Clayton Road, Clayton, Victoria from acute obstructive hydrocephalus complicating meningoencephalitis in the setting of previous left hemispherectomy for left hemispheric cortical malformation (FCD-2A); and

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

34. I convey my sincere condolences to HJ's family for their loss.

COMMENTS

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

35. Despite the family difficulties which led to the involvement of the Department of Health and Human Services, it is clear that his family carers were devoted and attentive. HJ's paediatrician Dr Monica Cooper stated '*NC took such good care of HJ. HJ was such a sweet boy, he had a magical spark and a cheeky sense of humor. HJ knew he was loved*'.

36. All of the evidence before me supports Dr Cooper's comments, and a report from OzChild confirms that NC was proactive in attending to HJ's medical issues and following up with specialists and other health professionals. There is no evidence that any failure on the part of HJ's carers, or his health professionals, was responsible for his tragic death from natural causes.

Pursuant to section 73(1B) of the Act, I direct that this de-identified copy of the finding be published on the Internet.

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

NC, Senior Next of Kin.

Liana Buchanan, Principal Commissioner for Children and Young People.

Katie Goode, Donatelife Victoria.

Peter Ryan, Monash Health.

First Constable Rachel Crocker, Coroner's Investigator.

Signature:

SIMON McGREGOR

CORONER

Date: 25 November 2020

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