IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 004438

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	GK
Date of birth:	26 November 2015
Date of death:	21 August 2019
Cause of death:	1(a) High grade pontine glioma
Place of death:	Monash Medical Centre, 246 Clayton Road, Clayton, Victoria
Key words:	In care, high grade pontine glioma, child protection, foster care

INTRODUCTION

1. On 21 August 2019, GK was three years old when he died in hospital due to a pontine tumour.

2. At the time of his death, GK was subject to an Interim Accommodation Order to the Monash Children's Hospital. Prior his admission to hospital, GK was subject to an Interim Accommodation Order to out of home care, residing in foster care placement through Berry Street Victoria.

3. GK's medical history included premature birth (34 + 2/40). There had been pre-natal exposure to drugs and alcohol and his mother was apparently alcohol intoxicated when found in labour by a roadside. GK also had a history of malnutrition and iron deficiency, developmental delay (normal microarray, normal metabolic studies, normal organ function, and B12 levels), behavioural problems, syndromic features (low set ears), positional plagiocephaly, and tooth decay.

THE CORONIAL INVESTIGATION

4. GK's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1] GK's status as a person placed in care immediately before death arises from the involvement of Child Protection and his placement at Monash Health on an Interim Accommodation Order.

5. 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.

6. 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

[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. This finding draws on the totality of the coronial investigation into GK's death. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Identity of the deceased

8. On 21 August 2019, GK, born 26 November 2015, was visually identified by his foster carer who signed a formal Statement of Identification to this effect.

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

Medical cause of death

10. Forensic Pathologist, Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 23 August 2019 and provided a written report of her findings dated 26 August 2019.

11. The post-mortem examination confirmed presence of a large intracranial posterior fossa tumour along with ventriculomegaly. Possible small volume subarachnoid haemorrhage was also seen, thought to be due to recent extra-ventricular drain insertion. Pectus excavatum was noted. The heart and mediastinum were also displaced to the right with a prominent right heart border and an aortic arch that appeared left-sided. The descending aorta was also noted to be on the left. A high density focus within the right kidney possibly represented a renal calculus. There was no evidence of unexpected skeletal trauma.

[2] 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.

12. Routine toxicological analysis of post-mortem samples detected methylamphetamine,[3] morphine,[4] temazepam[5] and oxazepam, and ketamine[6] and norketamine in hair, free morphine and midazolam[7] in blood, and morphine and codeine, midazolam, levetiracetam,[8] paracetamol,[9] and lignocaine in urine.

13. Dr Archer provided an opinion that the medical cause of GK's death was *"1(a) High grade pontine glioma"*, a natural causes death.

14. I accept Dr Archer's opinion.

Circumstances in which the death occurred

15. In the period from December 2015 to February 2017, the Department of Health and Human Services (**the Department**) Child Protection (**CP**) division received three reports regarding GK's welfare. These reports included concerns about a parent's (suspected) substance abuse, his general care and growth, and his exposure to family violence. These reports were closed due to CP either finding the concerns unsubstantiated or assessing them as suitable for a 'welfare' referral to the Child and Family Information Referral and Support Team (Child FIRST).

16. In August 2017, CP received a fourth report, also concerning a parent's substance use, which remained open until after GK's death. The Department found the report substantiated and CP became involved in GK's care and placement with various interventions and outreach visits to his family home occurring.

17. On 31 October 2018, GK attended an appointment with a paediatrician who noted he had *"severe global developmental delay including speech and language, fine motor, gross motor, social and play skills."* Recommendations were made for speech pathology, occupational

[3] Amphetamines is a collective word to describe central nervous system stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as 'speed' or 'ice', which is a strong stimulant. Amphetamine is also a metabolite of methamphetamine, benzfetamine, and selegiline. Amphetamines stimulate the central nervous system, causing persons to become hyperactive and more aroused. Blood pressure and heart rate are also increased.
[4] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain. Morphine is the primary constituent of crude opium and also a metabolite of codeine, ethylmorphine, heroin and pholcodine.
[5] Temazepam is a sedative/hypnotic drug of the benzodiazepine class. Oxazepam can also be formed by metabolism of temazepam.
[6] Ketamine is an anaesthetic normally used for short and medium duration operations as an induction agent.
[7] Midazolam is clinically used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent. It is a short-acting benzodiazepine.
[8] Levetiracetam is an antiepileptic used for the control of partial onset seizures.
[9] Paracetamol is an analgesic drug.

therapy, and psychologist intervention. At a further paediatric appointment in April 2019, possible autism spectrum disorder and iron deficiency were noted.

18. The Department continued to receive concerning reports about GK's family environment and on 20 June 2019 an Interim Accommodation Order was made placing GK in foster care for the first time.

19. The next day, GK's foster carer raised concerns about his physical presentation and development. On 24 June 2019, the first foster carer concluded that they were unable to care for him as:

> *... [GK] needed constant supervision, he was demanding, did not give cues to his needs, was nonverbal, would not make eye contact, was not responsive to his name and when 'he was distressed he went floppy and dropped to the ground, he was also pulling at his own hair'.*

20. There were difficulties finding another carer, so GK was place with an emergency foster carer overnight, which was his second placement in foster care.

21. On 25 June 2019, GK was placed with a third foster carer, which was an emergency short term placement.

22. On 27 June 2019, he was placed with a fourth foster carer. During this period, GK attended the Royal Children's Hospital for recommended blood and genetic tests, and he was given a high dose of vitamin D and iron.

23. On 1 July 2019, GK's placement again broke down and he was placed in an emergency short term placement, this being his fifth placement in foster care.

24. On 3 July 2019, GK was placed with a sixth foster carer, which was also an emergency short term placement. On this day, GK attended an audiology review and an assessment with a general practitioner who prescribed antibiotics and Ventolin.

25. On 4 July 2019, GK's foster carer advised the Department that his challenging behaviours were affecting the carer's family and this placement was also brought to an end. Prior to leaving the placement, GK's health deteriorated. He had a temperature, was reported to be *"staggering and uneasy"* and was taken to hospital where he was diagnosed with a bacterial fever. He was subsequently discharged on 11 July 2019 to his eighth foster care placement.

26. On 19 July 2019, GK attended reviews with a speech pathologist and occupational therapist.

27. On 31 July 2019, GK attended a neurological appointment at the Royal Children's Hospital. The neurologist advised that GK either had symptoms of severe neglect and exposure to substance abuse, a genetic syndrome, or ongoing seizures. He was referred for an MRI and follow-up appointment was made for October. It was also recommended that he attend a dentist.

28. On 2 August 2019, GK was found unresponsive by his foster carer. He was resuscitated and transported via ambulance to the emergency department of Monash Medical Centre. A CT scan revealed a large posterior fossa tumour, hydrocephalus, and tonsillar herniation. Neurosurgery inserted an external ventricular drain to relieve hydrocephalus. GK was transferred to the Paediatric Intensive Care Unit where neurocritical care was instituted.

29. On 5 August 2019, a fine needle biopsy revealed histopathology of high-grade glioma. Clinically GK had a dense left hemiparesis, moderate right sided weakness, and absent brainstem reflexes.

30. On 6 August 2019, the Department made an application for an Interim Accommodation Order placing GK into the care of the Monash Children's Hospital, which was granted by the Children's Court.

31. Following a multidisciplinary meeting involving Paediatric Intensive Care Unit, Oncology, and Neurosurgery on 9 August 2019, it was determined that further treatment would be futile as GK's condition was not survivable.

32. GK's foster parents and biological parents were informed, and his care plan was redirected to comfort care. GK was extubated on 13 August 2021 and the external ventricular drain was removed on 15 August 2019.

33. GK was kept comfortable until he passed away peacefully on the Paediatric ward at 7.12am on 21 August 2019.

FURTHER INVESTIGATION

34. As part of my investigation and to understand whether there were any prevention opportunities, I sought advice from the Coroners Prevention Unit[10] (**CPU**) regarding GK's cause of death.

35. The CPU explained that a high-grade glioma in the pontine region was a highly aggressive tumour and in terms of mechanism, GK ultimately died as expected due to the mass effect of the tumour on his brain. Death was likely to occur within a short period irrespective of the clinical management and care provided to him.

36. The CPU further explained that it was very likely that there would have been minimal warning, especially so in the context of his behavioural/developmental issues, including the possibility of autism spectrum disorder. Furthermore, it was unlikely that medical practitioners involved in his care would have had the opportunity to investigate for this as a possibility in light of GK's other issues and absence of specific signs that might have pointed them to a brain tumour.

37. The CPU did not identify any areas of concern with the clinical management and care provided to him. I agree with and accept the CPU's advice.

Conclusion

38. It is evident that GK experienced an extremely difficult young life. There were multiple reports of parental substance abuse and family violence and evidence of nutritional and medical neglect. While the Department and various services were involved, his family environment was ultimately deemed unsafe, and he was placed in foster care. Sadly, GK did not receive the stability he required as he was moved to multiple foster homes over a two-week period due to inadequate placement options in the context of his complex behavioural and support needs. When he was found unresponsive and taken to hospital, his fatal condition was finally revealed.

39. Despite all of the social and medical issues GK experienced, there is no evidence before me that attributes or connects his cause of death to these issues. I am satisfied that GK's death

[10] The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

was due to an aggressive brain tumour the earlier diagnosis of which was likely confounded by his behavioural and developmental issues.

FINDINGS AND CONCLUSION

40. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was GK, born 26 November 2015;

(b) the death occurred on 21 August 2019 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria;

(c) the cause of GK's death was high grade pontine glioma; and

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

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

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Senior next of kin
Barwon Health
Monash Health
Royal Children's Hospital
Commission for Children and Young People
Council on Obstetric and Paediatric Mortality and Morbidity
Department of Families, Fairness and Housing
Senior Constable Matthew Anderson, Victoria Police, reporting member

Signature:

Coroner Paresa Antoniadis Spanos

Date: 18 November 2022

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.