IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 2470

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	KTJ[1]
Date of birth:	16 July 2003
Date of death:	12 May 2021
Cause of death:	1(a) Metastatic Ewing sarcoma (palliated)
Place of death:	Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria

[1] This Finding has been de-identified to replace the names of the deceased and their family members with pseudonyms of randomly generated three letter sequences to protect their identity and to redact identifying information.

INTRODUCTION

1. On 12 May 2021, KTJ was 17 years old when she passed away from natural causes. At the time of her passing, KTJ resided in Victoria with her family.

2. KTJ was a proud young Aboriginal woman who had connections to her community and cultural heritage. Her mother is of the Gurnaikurnai and Yorta Yorta people, traditional owners of Gippsland and lands that lie on both sides of the Murray River from Cohuna to Albury/Wodonga respectively. Her father is of the Noongar (Minang) people, traditional owners of the lands in Southern Western Australia.

THE CORONIAL INVESTIGATION

3. KTJ's passing 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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes. As KTJ was under the care of the Department of Families, Fairness and Housing, she was deemed to be a person in care or custody.

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 Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of KTJ's passing. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into KTJ's passing, including evidence contained in the coronial brief. 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 12 May 2021, KTJ, born 16 July 2003, was visually identified by her grandmother.

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

Medical cause of death

10. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of the circumstances on 13 May 2021 and provided a written report dated 8 June 2021.

11. As KTJ was not received into the care of the VIFM after her passing, Dr Bouwer reviewed the medical records and noted the following:

> *[KTJ] was a 17 year old adolescent who was diagnosed with a left tibia Ewing sarcoma, high volume tumour and a high risk at the time of diagnosis. She underwent surgical resection of the tumour in November 2015 followed by intensive chemotherapy, which was completed in May 2016. She had relapsed disease diagnosed in February 2019 with right mediastinal and right pleural disease. [KTJ] underwent further intensive chemotherapy (supported with stem cell transplant), and radiotherapy to her lungs. She was clinically well until December 2020, when she presented with difficulty breathing, and was found to have right pleural effusion, hilar disease and new right pulmonary metastases. [KTJ]'s care was shifted to a palliative approach at that time, with a chest drain for pleural effusion, and palliative radiotherapy to her chest. She was admirably cared for by her extended family with the support of community palliative care providers and died peacefully at home.*

12. Dr Bouwer provided an opinion that the medical cause of death was *"1(a) Metastatic Ewing sarcoma (palliated)",* and due to natural causes.

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[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.

13. I accept Dr Bouwer's opinion.

Circumstances in which the passing occurred

14. At the time of her passing, KTJ was in the care of the Department of Families, Fairness and Housing (**the Department**) and she resided with her great aunt. She maintained a close relationship with her mother and resided with two of her five siblings.

15. In mid-2015, at the age of 12 years, KTJ was diagnosed with Ewing's Sarcoma[3] and underwent treatment at the Monash Children's Hospital, which involved multiple rounds of chemotherapy over 11 months. All decisions regarding her care involved KTJ, her extended family, the Victorian Aboriginal Child Care Agency (**VACCA**), and the Department.

16. Chemotherapy was finalised in May 2016 and at an annual review at the Royal Children's Hospital in February 2017, scans did not detect any cancer.

17. In February 2019, tests detected that the cancer had returned with a large mass at the top of her chest and a small patch at the bottom of her lung. Chemotherapy recommenced in March and was supplemented with stem cell transplants and radiation.

18. KTJ remained well for most of the year until December 2020 when she was readmitted to Monash Children's Hospital for fluid on her lungs. New scans showed the cancer had spread to her lung and required treatment. She decided not to undergo further chemotherapy and commenced radiation for symptom control.

19. Later that month, a family meeting and multi-discipline meeting took place at the hospital where progression of the disease and treatment options were discussed. Extensive services, including palliative care, were put in place to allow KTJ to return home, which was her wish.

20. In April 2021, KTJ's health deteriorated, and her palliative care team implemented end-of-life care.

21. KTJ passed peacefully at 10.10am on 12 May 2021, surrounded by her family.

FINDINGS AND CONCLUSION

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

[3] A cancerous tumour that forms in the bone or soft tissue. It occurs primarily in children and young adults.

(a) the identity of the deceased was KTJ, born 16 July 2003;

(b) her passing occurred on 12 May 2021 at Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria, from metastatic Ewing sarcoma (palliated); and

(c) her passing occurred in the circumstances described above.

I convey my sincere condolences to KTJ'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

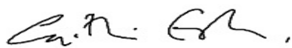
Royal Children's Hospital

Monash Health

Commission for Children and Young People

Senior Sergeant Greigory McFarlane, Victoria Police, Coroner's Investigator

Signature:



Caitlin English, Deputy State Coroner

Date: 15 March 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.