IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003398

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Dimitra Dubrow
Deceased:	Baby E[1]
Date of birth:	On a date known to the Court
Date of death:	In 2024
Cause of death:	1a : COMPLICATIONS FROM SEVERE CEREBRAL PALSY
Place of death:	The Royal Children's Hospital Melbourne 50 Flemington Road Parkville Victoria 3052
Keywords:	Child death, Care by Secretary Order, Kinship Carer, foster care, natural causes, cerebral palsy

[1] Pursuant to section 534 of the *Children Youth and Families Act 2005* (Vic) several individuals mentioned in this Finding have been deidentified by the use of pseudonym. Some details have been intentionally omitted from this Finding but remain known to the Court.

INTRODUCTION

1. In 2024, Baby E was 3 years old when she died in hospital. She was deeply loved and she is fondly remembered by her biological family and kinship carer.

BACKGROUND

2. Baby E had a complex medical history including cerebral palsy, spastic quadriplegia, bulbar dysfunction, upper airway obstruction, severe hypoxic ischaemic encephalopathy and required a gastrostomy tubing for feeding. She experienced seizures, had cortical blindness and hearing loss. She required 24/7 high-level support.

3. During her early life, Baby E lived with her mother and siblings. Between September 2020 and May 2021, Baby E was the subject of six reports to Child Protection regarding her biological mother's ability to provide adequate care in the context of Baby E's medical needs (among other factors).

4. In May 2021, a Protection Application was issued, and Baby E was initially subject to an Interim Accommodation Order (**IAO**) to a hospital placement, then an IAO to parent between June 2021 and September 2021. She was eventually placed on a Care by Secretary Order which was due to expire in February 2026.[2]

5. Around this time, Baby E began living with a foster family (out of home care). She received support from several care workers through the National Disability Insurance Scheme (**NDIS**), the Mallee Family Care including Placement Support Worker, Ms Perry,[3] and allied health practitioners.

6. Around July 2023, Baby E's foster carer no longer felt they could provide an adequate level of care and Ms Perry began searching for another family. Unfortunately, no alternative could be found, and Baby E faced the possibility of living in a hospital or aged care facility. Ms Perry offered to become Baby E's foster carer became a kinship carer under the Department of Families, Fairness and Housing (**DFFH**).

7. Ms Perry fondly recalled her time with Baby E. They would watch television together and go for walks in the afternoon, often taking the family dog with them.

[2] The Care by Secretary Order (**CBSO**) was preceded by an IAO to out-of-home care and a Family Reunification Order.
[3] A pseudonym.

8. She also described Baby E's poor health including multiple seizures, of varying lengths,[4] specialist consultations and hospital admissions.

THE CORONIAL INVESTIGATION

9. Baby E'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.

10. At the time of her death, Baby E was subject to a Care by Secretary Order and therefore parental responsibility was held by the Secretary to the Department of Families Fairness and Housing. Baby E was therefore a *'person placed in custody or care'* pursuant to section 3(d) of the Act.

11. 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.

12. 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.

13. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Baby E's death. The Coronial 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.

14. This finding draws on the totality of the coronial investigation into the death of Baby E 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.[5]

[4] Ms Perry recalled a seizure in December 2023 which exceeded 20 minutes in duration.

[5] 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

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

Circumstances in which the death occurred

15. In mid-2024, Baby E experienced several seizures and multiple Ambulance Victoria visits. She began producing dark green sputum and was prescribed antibiotics.

16. A few weeks later, during the early morning, Baby E was *'restless'* and vocalising in discomfort. Ms Perry attempted to relieve her by suctioning her airways using an at-home machine.

17. The same morning, they attended a physiotherapist appointment during which Baby E's temperature lowered. Despite momentarily improving, by around 1:45pm, her eyes appeared *'glassy'*, she was drowsy, had a body temperature of 30.2°C and laboured breathing. Ms Perry contacted emergency services and Baby E was transported to Bendigo Base Hospital before being transferred to the Royal Children Hospital where she was admitted to the Intensive Care Unit (**ICU**).

18. Imaging and pathology were performed and clinicians identified compensated respiratory acidosis and sepsis. She was treated for presumed chest sepsis, commenced on BiPAP[6] respiratory support and physiotherapy for secretion clearance. She tested positive for rhinovirus/enterovirus.

19. During her admission, Baby E's condition fluctuated and she was moved between the ward and ICU. She continued to experience several seizures.

20. A meeting was held between clinicians, Ms Perry and representatives of the DFFH. Baby E's condition was discussed including her care needs if she were to return home. They also discussed palliative care and end of life options.

21. By that evening, after further seizure activity, a clinician spoke to Ms Perry and advised her that Baby E's condition had declined and her prognosis was poor**.** By this time, she had signs of hypothermia, decreased respiratory drive and decreased consciousness.

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[6] A form of non-invasive ventilation which uses a machine and mask to deliver pressurised air.

22. The DFFH and Baby E's biological mother were also informed. Over the following days, Baby E was cared for by Ms Perry and her biological mother who made sure she was comfortable.

23. 20 days after her admission to hospital, Baby E passed away peacefully in Ms Perry's arms surrounded by her foster siblings.

Identity of the deceased

24. On 18 June 2024, Baby E, born on a date known to the Court, was visually identified by her kinship carer, Ms Perry.

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

Medical cause of death

26. Forensic Pathologist Dr Paul Bedford of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 20 June 2024 and provided a written report of his findings dated 27 June 2024.

27. The post-mortem CT scan showed moderate to marked hydrocephalus[7] and bilateral lung changes.

28. Dr Bedford provided an opinion that the medical cause of death was 1(a) COMPLICATIONS FROM SEVERE CEREBRAL PALSY. Dr Bedford also provided an opinion that the death was due to natural causes.

29. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

30. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Baby E, born on a date known to the Court;

    b) the death occurred in 2024 at The Royal Children's Hospital Melbourne 50 Flemington Road, Parkville Victoria 3052, from 1(a) COMPLICATIONS FROM SEVERE CEREBRAL PALSY; and

[7] Abnormal build up of fluid in the ventricles of the brain, causing increased pressure.

c) the death occurred in the circumstances described above.

31. I have considered the evidence and have not identified any want of care provided by the Royal Children's Hospital or the Department of Families Fairness and Housing that caused or contributed to Baby E's death.

32. On the factual matrix, I have not identified any causal connection between Baby E's status as a person under custody or care under the Act and her death and therefore have determined not to hold an inquest into her death pursuant to section 52(3A).

I convey my sincere condolences to Baby E's family and carers for their loss. It is evident that she was dearly loved and was deeply cared for by those around her and thank Baby E's foster carer and kinship carer for their care of Baby E. I also acknowledge the response and role of the Department of Families Fairness and Housing as part of Baby E's care team and in facilitating care arrangements.

Pursuant to section 73(1) 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:

Ms Perry, Kinship carer

Ms Rachel Smith, Child Protection, Department of Families Fairness and Housing

Royal Children's Hospital

Commissioner for Children and Young People

Senior Constable Thomas Gillahan, Coronial Investigator

Signature:

Coroner Dimitra Dubrow

Date: 04 May 2026

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.