Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 9/16

I, Sarah Helen Linton, Coroner, having investigated the death of ***Baby Z*** *with an inquest held at the* ***Perth Coroner's Court, Court 58, CLC Building, 501 Hay Street, Perth*** *on* ***14 – 17 March 2016*** *find that the identity of the deceased person was* ***Baby Z*** *and that death occurred on* ***3 April 2011*** *at* ***Bandyup Women's Prison*** *as a result of an* ***unascertained cause*** *in the following circumstances:*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Ms S Teoh (State Solicitor's Office) appearing on behalf of the Department of Corrective Services, the Department of Health and the Department of Child Protection.
Ms J Lee (Australian Nursing Federation) for Ms Barton.

SUPPRESSION ORDER

The name of the deceased and any identifying information are suppressed from publication. The deceased is to be referred to as Baby Z.

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INTRODUCTION

1. Baby Z was born on 3 March 2011 at King Edward Memorial Hospital (KEMH). His mother was a sentenced prisoner at Bandyup Women's Prison (Bandyup) at the time he was born. Both mother and baby spent some time at the hospital after the birth for various reasons and then on 21 March 2011 Baby Z and his mother were discharged back to Bandyup. The Department of Child Protection and Family Support (DCP) were actively involved with Baby Z's mother prior to the birth, and after the birth, of Baby Z.

2. Once at Bandyup, Baby Z was housed with his mother in the Nursery Unit. He was not a prisoner, but was permitted to stay with his mother as a 'visitor' pursuant to a prison policy that allows female prisoners and their young babies (generally up to 12 months) to live together in prison under certain circumstances.

3. There were no significant concerns raised about Baby Z's health or care while at Bandyup until he was found deceased by his mother at around 3.30 am on 3 April 2011. He was only one month old.

4. Given the circumstances of Baby Z's death, his death was treated by the then State Coroner as the death of a person held in care, thus requiring an inquest to be held into his death pursuant to section 22(1)(a) of the *Coroners Act 1996* (WA). I held an inquest at the Perth Coroner's Court from 14 to 17 March 2016.

5. The issues that were identified as primary areas for consideration at the inquest were:[1]

   - What protocols were in place for information sharing between KEMH, Bandyup and the DCP, and were they followed?
   - Did all of the relevant parties have the necessary information about Baby Z and his mother to properly consider the decisions to allow Baby Z to be discharged from hospital and to allow him to reside with his mother at Bandyup?
   - What did the relevant parties do to ensure that Baby Z was appropriately monitored once he was at Bandyup?

6. The documentary evidence included six volumes of materials, including witness statements and relevant policy documents.[2] In addition, a number of documents were tendered during the inquest.[3] Various witnesses were also called to give oral evidence in relation to their dealings with Baby Z and his mother, as well as to address the broader policy issues that were raised by his death.

[1] T 6.
[2] Exhibits 1 – 6.
[3] Exhibits 3 – 10.

RELEVANT BACKGROUND

7. Baby Z's mother had a troubled childhood and as an adult she had a history of illicit drug abuse and criminal offending, which resulted in numerous periods of incarceration.[4]

8. In late November 2007 Baby Z's mother came to the attention of DCP as she was 34 weeks pregnant with her first child and a regular heroin user and had left KEMH against medical advice. Medical staff considered it likely that her baby would be born drug addicted and would need to go through drug withdrawal post birth and they were concerned that she could not be located. She was eventually taken into custody for breaching her parole conditions and remained at KEMH until the birth of her daughter on 13 December 2007 by caesarean section due to placenta praevia (an obstetric complication).[5]

9. The baby initially remained with Baby Z's mother but on 17 December 2007 KEMH staff contacted DCP expressing concerns for the safety of the baby. The previous evening Baby Z's mother had been drowsy and staff had found the baby well under the covers and also under Baby Z's mother's body, next to the breast. The baby was taken into Provisional Protection and Care by DCP on the same day, although she remained with her mother in the hospital.[6]

10. Following discharge from KEMH the baby initially resided with her mother in Bandyup from Monday to Friday and with her father on weekends. On 16 May 2008 the baby was delivered to her father's care full time and Baby Z's mother was later granted supervised contact.[7]

THE PREGNANCY

11. In 2010 Baby Z's mother became pregnant again, this time with Baby Z. Her partner and Baby Z's father, was a different man to the father of her first child. Baby Z's mother stated that before she found out she was pregnant she was using heroin on a daily basis, injecting four to five times a day.[8] She used heroin until she went into hospital for an infection. She was in extremely poor health at that time. The hospital staff referred her to Next Step, who later arranged for her to start on methadone to manage her opiate addiction.[9]

12. On 4 November 2010 staff from Royal Perth Hospital contacted DCP expressing concerns for the unborn baby. They believed the baby would be at risk of harm due to Baby Z's mother's heroin use and homelessness. She was also believed to be at risk of being subjected to

[4] Exhibit 2, Tab 1, p. 1.
[5] Exhibit 1, Tab 32, p. 1; Exhibit 2, Tab 1, p. 1.
[6] Exhibit 2, Tab 1, p. 2.
[7] Exhibit 2, Tab 1, p. 2.
[8] Exhibit 1, Tab 8 [8].
[9] Exhibit 1, Tab 8 [9].

domestic violence by her partner. The case was intaked on the same day by DCP Cannington district.[10]

13. Baby Z's mother was discharged from Royal Perth Hospital to Bandyup, where she was detained on outstanding warrants. While at Bandyup the deceased was referred to KEMH Antenatal Clinic in relation to her pregnancy. She had received no antenatal care up to that time and was identified as being opiate dependent and on the methadone maintenance programme.[11] Based on that information the deceased was booked to the Women and Newborn Drug and Alcohol Service (WANDAS) for her antenatal care and she was then reviewed regularly by the WANDAS midwives.[12]

14. On 29 November 2010 Baby Z's mother was sentenced to a custodial term of 10 months' imprisonment. She was scheduled for release on 26 April 2011, approximately one month after her estimated due date of 24 March 2011.[13]

15. DCP staff initiated contact with Baby Z's mother, Bandyup staff and KEMH staff to commence pre-birth planning for the unborn child. The intention was to conduct Signs of Safety pre-birth planning meetings that would be used to share information between Baby Z's mother, DCP and other support agencies to ensure that Baby Z would be well cared for and safe after his birth.[14] The ultimate outcome of the signs of safety meetings is "to determine whether the child is going to be safe with the parent or the child is in need of care and protection."[15]

16. An initial Signs of Safety meeting was held at Bandyup on 13 January 2011, when Baby Z's mother was 30 weeks pregnant. The meeting was attended by Baby Z's mother, Georgina Ackers (who was the Early Childhood Educator at Bandyup), a senior social worker from KEMH, Natalie Poulter (Baby Z's mother's case worker from DCP at that time) and Ms Poulter's Acting Team Leader at DCP.

17. During the meeting the DCP staff outlined their specific concerns for the safety of Baby Z once he was born and Baby Z's mother expressed her concern that DCP might take her baby from her. Most of the comments about how Baby Z's mother was managing her pregnancy and engaging with ante-natal care were positive. A primary concern was that Baby Z's mother did not have a plan as to where she would live after release from prison, so it was agreed that steps would be taken to explore supportive housing options for her on release.[16] It was intended that DCP would decide whether to take statutory action before the next meeting.[17]

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[10] Exhibit 2, Tab 1, p. 2.
[11] Exhibit 1, Tab 32, p. 1.
[12] Exhibit 1, Tab 32, p. 1.
[13] Exhibit 1, Tab 2, p.1; Exhibit 2, Tab 1, p. 2.
[14] Exhibit 2, Tab 1.1.
[15] T 254.
[16] Exhibit 2, Tab 1.1.
[17] Exhibit 2, Tab 1.1.

18. As a side-note, it is DCP's usual practice to try to coordinate three Signs of Safety meetings prior to the baby being born and make a decision as to whether statutory action would be taken *prior to* the birth. However, because the pregnancy in this case only became known to DCP quite far into the pregnancy and Baby Z's mother had complex health issues, the usual timing of the meetings was unable to be followed.[18] However, the general information available at the first meeting indicated that the plan was moving towards safety planning with Baby Z's mother, with a view to using her incarceration as an opportunity to work with her on the identified safety issues prior to release, so that she would be able to have an opportunity to parent her baby. This was the preliminary plan, provided no obvious signs of poor caregiving emerged after the baby was born.[19]

19. On 4 February 2011 Baby Z's mother was seen at the KEMH Antenatal Clinic by Dr Dale Hamilton, a Consultant Obstetrician and Gynaecologist based at KEMH. She was at 33 weeks gestation at that time. An ultrasound performed that day revealed placenta praevia (the same obstetric complication that arose during her first pregnancy). Baby Z's mother also had severe peripheral oedema (swelling), which was causing her to feel unwell, and she complained of carpal tunnel syndrome. It is standard practice to admit cases of placenta praevia at around 34 weeks' gestation because of the risk of sudden and dramatic haemorrhage. Accordingly, arrangements were made to admit Baby Z's mother to KEMH the following week.

20. Baby Z's mother was admitted under the care of Dr Hamilton on 7 February 2011, when she was at 33 weeks and 4 days' gestation. She was on 60mg of methadone daily at that time and was also given some medications for a tooth abscess and constipation.

21. On 15 February 2011 Baby Z's mother became angry and distressed as she was fearful that her violent ex-partner might learn of her whereabouts. She requested to return to prison but an ultrasound confirmed that she still had major placenta praevia, which meant it was medically unsafe for her to return to prison. Dr Hamilton explained to Baby Z's mother that the prison would not accept her back in these circumstances.[20]

22. In addition to her safety concerns while in hospital, Baby Z's mother also experienced psychological distress in hospital from restrictions on her movement and ability to smoke because she was a prisoner under guard. Unlike in prison, where Baby Z's mother would have been free to move about and socialise and smoke as desired, in hospital she was confined to a single non-smoking room with guards outside the door. Telephone calls and visits were also restricted.

[18] T 241; Exhibit 1, Tab 43 [15] – [16].
[19] T 240 – 242; Exhibit 1, Tab 43 [19].
[20] Exhibit 1, Tab 32, p .2.

23. Baby Z's mother was reviewed by Dr Binns, a Consultant Psychiatrist, on 16 February 2011 following angry outbursts related to the restrictions. She was prescribed lorazepam and temazepam by Dr Binns to help contain the frustration and stress of her situation. Some slight extension to her permitted movements on the ward was also approved by the prison authorities, although no suitably safe area could be found to permit her to smoke.[21] Baby Z's mother was offered nicotine replacement therapy, but she declined.[22]

24. The lorazepam was later substituted for quetiapine and she was also prescribed diazepam on an "as required" basis by Dr Hamilton after discussion with Dr Binns on 24 February 2011.[23]

25. On 28 February 2011 an ultrasound reported results that indicated an abnormality involving the placenta and the uterine wall. This indicated that a caesarean section would be difficult and likely to be associated with severe haemorrhage and require hysterectomy. Baby Z's mother was informed of these findings and the attendant risk to her future fertility, which understandably caused her great anxiety and distress.[24]

26. Baby Z's mother remained at KEMH and underwent daily review by medical staff and regular fetal monitoring. Apart from the ongoing oedema and psychological distress, Baby Z's mother remained well, and fetal growth remained on the 95th percentile. A caesarean section was planned for 3 March 2011.[25]

27. The second Signs of Safety meeting was scheduled for 2 March 2011, the day before the caesarean. Given the timing and Baby Z's mother's noted anxiety, KEMH staff requested DCP staff postpone the second Signs of Safety meeting and reschedule the meeting to Bandyup sometime after the birth. The relevant DCP Acting Team Leader, Jacinta Maxton, agreed to the proposal on the proviso that following the birth Baby Z's mother demonstrated a clear attachment towards the baby, met the baby's needs as a priority and was able to demonstrate appropriate coping strategies when the baby was unsettled, etc. If Baby Z's mother did not attend to the baby as specified, Ms Maxton indicated that KEMH staff needed to notify DCP so an assessment could be made of her capacity to provide safe care to the baby.[26] No specific date was set for the next meeting at that time.

THE BIRTH

28. The deceased was delivered by caesarean section on 3 March 2011, as planned. Following his birth a hysterectomy was performed on Baby Z's mother because of the placenta accreta. The surgery, while difficult,

[21] Exhibit 1, Tab 32, p. 3.
[22] Exhibit 1, Tab 32, p. 4.
[23] Exhibit 1, Tab 32, p. 3.
[24] Exhibit 1, Tab 32, p. 3 – 4.
[25] Exhibit 1, Tab 32, p. 3.
[26] Exhibit 2, Tab 1.2.

went smoothly with a modest amount of blood loss in the circumstances.

29. Baby Z experienced respiratory distress syndrome at birth and required resuscitation.[27] It was not clear why he was born in this condition although it was thought that it may have related to maternal sedation or due to the caesarean section not squeezing the baby in the same way as vaginal delivery.[28] He showed ongoing mild respiratory distress and was subsequently managed for hyaline membrane disease, most likely a result of being born at only 37 weeks.[29]

30. Post-operatively Baby Z's mother was taken to the Adult Special Care Unit, which is standard practice for a patient following caesarean hysterectomy, and Baby Z was transferred to the Special Care Nursery.

31. Given his mother's history of taking daily methadone during pregnancy, Baby Z was observed for features of neonatal abstinence syndrome. This is a generalised disorder of drug withdrawal in the infant. Up to 90% of infants of mothers on methadone will experience some withdrawal and 50-75% will require treatment.[30] Baby Z's observation chart scores for signs of neonatal abstinence syndrome varied considerably and were generally not reflective of withdrawal symptoms. He was given one dose or oral morphine on 7 March 2011 but thereafter his scores were below treatment levels.[31]

32. It was observed that Baby Z's mother was breastfeeding and expressing breast milk for Baby Z at this time,[32] which is recommended for mothers on methadone as the small dose of methadone transferred through the breast milk to the baby helps to wean the baby off the intrauterine exposure to opiates.[33] Without being breastfed, it is likely Baby Z would have experienced greater symptoms of withdrawal, ranging in seriousness, including fits or seizures in the worst cases.[34]

33. Baby Z's general assessment was that he was a term baby who needed a little bit more support after birth but would recover from his respiratory distress and would go on to feed and grow normally.[35] The possibility of drug withdrawal had been explored but all his symptoms were found to be directed towards respiratory issues, with no features of withdrawal.[36]

34. On 4 March 2011 Baby Z's mother was transferred from the Special Care Unit to a ward for postnatal care. The following day she complained of severe post-surgical pain and the Anaesthetic Pain

[27] T 112; Exhibit 1, Tab 30; Exhibit 6, Neonatal history.
[28] Exhibit 1, Tab 30.
[29] T 112; Exhibit 1, Tab 30.
[30] Exhibit 1, Tab 26, CH1, 5.4.17.
[31] Exhibit 1, Tab 33, p. 1.
[32] Exhibit 1, Tab 32, p. 6.
[33] T 38; Exhibit 1, Tab 33, p. 2.
[34] T 38, 55.
[35] T 37, 117.
[36] T 113.

Service added ketamine lozenges to the usual opiate (Oxycodone) pain relief she was receiving. Dr Hamilton noted that it was unsurprising that Baby Z's mother required additional pain relief as adequate pain relief can be difficult for women on methadone due to their high tolerance to opiate medications. Her post-operative pain was also expected to be higher because of the type of incision required for the caesarean hysterectomy.[37]

35. Baby Z's mother was discharged back to Bandyup on 8 March 2011 while Baby Z remained in the Special Care Nursery at KEMH. Prior to her discharge Baby Z's mother had been visited on a number of occasions by the KEMH social worker dealing with Baby Z's case, Ms Hannah Staines, who was the social worker based in the Special Care Nursery. Ms Staines' role was to liaise with DCP, Bandyup and the medical teams on the ward and nursery. Ms Staines believed at that time the decision had been made by DCP that Baby Z was to go with his mother to Bandyup, but she was still involved in monitoring his mother's attachment and was aware that she was to report on her parenting ability.[38] In that first period before discharge Ms Staines had not been able to make any clear assessment about Baby Z's mother's mothercrafting skills although she was not aware of any issues of concern being raised at that stage.[39]

36. Baby Z's mother was readmitted to KEMH under Dr Hamilton's care during the evening of 9 March 2011 due to her poorly controlled pain and a possible surgical wound infection. She was continued on her methadone as well as being prescribed ibuprofen, paracetamol, ketamine lozenges and tramadol for pain control. Diazepam and quetiapine were added to the medication chart on an 'as required' basis for anxiety and agitation.[40] Prior to her readmission it had been planned that Baby Z was going to be discharged to Bandyup in the next couple of days to be with his mother.[41]

37. On 10 March 2011 Baby Z's mother was noted to be extremely drowsy and the Anaesthetic Pain Service was consulted on how to medicate her to achieve good pain control without the excessive drowsiness.[42]

38. On 12 March 2011 Baby Z's mother was again noted to be extremely drowsy and complaining of pain in spite of the large amount of analgesia prescribed. Registered Nurse and Midwife Robyn Turner had noticed Baby Z's mother falling asleep numerous times while feeding her baby and was concerned about his safety from that perspective, although Baby Z's mother otherwise appeared to her to be a very caring towards Baby Z.[43] Baby Z's mother was reviewed by the Resident Medical Officer, who felt that she may be developing a collection of fluid

[37] Exhibit 1, Tab 32, p. 4.
[38] T 206; Exhibit 1, Tab 63 [16], [18] – [19], [21].
[39] Exhibit 1, Tab 63 [21] – [22].
[40] Exhibit 1, Tab 32, p. 5.
[41] Exhibit 1, Tab 63 [23].
[42] Exhibit 1, Tab 32, p. 5.
[43] Exhibit 1, Tab 28 [22] – [27], [37].

under the wound (which was later confirmed by ultrasound). She was also reviewed by the anaesthetist, who prescribed additional medications in the form of regular slow release tramadol and gabapentin as well a reduction of her ketamine in order to try and reduce the drowsiness.

39. On 13 March 2011 Baby Z's mother raised her own concerns about her level of drowsiness, which she attributed to her pain medications. She expressed concern that it was affecting her interactions with Baby Z.[44] Dr Tim Pavy, the Head of the Department of Anaesthesia and Pain Medicine at KEMH, gave evidence at the inquest that the combination of gabapentin, diazepam and methadone was "a fairly potent cocktail"[45] that would explain the high levels of sedation Baby Z's mother was experiencing at that time.

40. On 14 March 2011 Ms Staines had a conversation with Baby Z's mother about her reportedly aggressive behaviour in the nursery over the previous weekend and also advised DCP of this conversation.[46]

41. On 15 March 2011 Baby Z's mother was taken to theatre and her surgical wound was partially opened and the fluid drained, as it was felt this was contributing to her excessive pain. While in theatre a further epidural was inserted and the ketamine lozenges were ceased.[47]

42. Ms Staines spoke to Ms Claire Byrne (as she then was), the relevant case worker at DCP, on 15 March 2011 and Ms Byrne told her that the DCP plan was that once Baby Z was medically cleared for discharge he would either be discharged to the ward, if his mother was still at KEMH, or else discharged to Bandyup to be with his mother if she had returned to prison.[48] Ms Byrne had not been involved in the initial Signs of Safety meeting with Baby Z's mother so she had not met Baby Z's mother directly, but had received a handover of the case from another DCP worker.[49]

43. That same day Ms Staines became aware there were still concerns from the nursing staff in the Special Care Nursery that Baby Z's mother was excessively drowsy. They expressed concern that she might drop Baby Z as a result. Dr Pirie, who was employed as a Senior Paediatric Registrar at the time, made a note after speaking with Ms Staines, as follows:[50]

> We are <u>not</u> happy with baby going to mum at present. Our primary concern is how drowsy mum appears when she is with baby. This would be a real concern for baby's ongoing care. If mum is drowsy, because of medical condition and things resolve as mum gets

[44] Exhibit 6, Tab 1, Neonatal Inpatient Progress Sheet 100028, 13.3.11, 19.30 hrs.
[45] T 232.
[46] Exhibit 1, Tab 63 [26].
[47] Exhibit 1, Tab 32, p. 5.
[48] Exhibit 1, Tab 63 [27] – [28]; Exhibit 6, Neonatal Inpatient Progress Notes 100029, 15.3.11; Social Work.
[49] Exhibit 1, Tab 43.
[50] Exhibit 6, Tab 1, Neonatal Inpatient Progress Notes 100032, 15.3.11, 13.50 hrs.

better this could be ok. If, however, the drowsiness is related to other medications we are worried about the safety of baby being looked after by a very drowsy mother.

44. Ms Staines notified Ms Byrne at DCP by email of the concerns raised by the medical team that day. Until then Ms Byrne had been working towards arranging for Ngala staff to assess Baby Z's mother and Baby Z once they were both back in Bandyup.[51] Ms Byrne had only started at DCP the previous month so she had little experience in this sort of situation.[52] Ms Staines was also the newest member of the social work team at KEMH, having only started working there in December 2010, and this was her first WANDAS case and first baby of a serving prisoner.[53]

45. The following day, being 16 March 2011, Ms Staines spoke to the medical team who were caring for Baby Z's mother. Ms Staines was told that Baby Z's drowsiness was possibly due to her pain management medications and she was reassured that Baby Z's mother was to be reviewed by the Anaesthetic Pain Service. On that basis, Ms Staines noted it was premature to make a judgment in regard to Baby Z's mother's capacity to mothercraft.[54] Ms Staines also noted that, having informed DCP of the concerns about Baby Z's mother's drowsiness, at that time the plan was still for Baby Z to be discharged to Bandyup with his mother.[55]

46. Dr Hamilton did review Baby Z's mother that day and she then discussed a plan to reduce her pain medication with the Anaesthetic Pain Service staff.[56]

47. On 17 March 2011 Baby Z's mother was reviewed by the Psychiatry Registrar, Dr Magtengaard. Dr Magtengaard had taken over her care from Dr Binns back in February 2011 and had been seeing Baby Z's mother regularly while she was at KEMH. Dr Magtengaard works with the WANDAS team at KEMH and has significant experience working with patients who have psychiatric issues in the context of significant substance and alcohol abuse.[57] Dr Magtengaard did not observe any signs of excessive sedation in Baby Z's mother that day, although she had complained of feeling sedated when he saw her the day before. He attributed her earlier sedation to a combination of the general anaesthetic, the stress of major surgery and her ongoing pain relief.[58] Dr Magtengaard did not observe evidence of any active psychiatric condition such as pervasive depressive disorder or psychotic disorder at any time that he was reviewing Baby Z's mother.[59] She reported being

[51] T 242; Exhibit 1, Tab 43 [26] – [28].
[52] T 243.
[53] T 206, 208; Exhibit 1, Tab 63 [3].
[54] Exhibit 6, Tab 1, Neonatal Inpatient Progress Notes 100030, 16.3.11, Social Work.
[55] Exhibit 6, Tab 1, Neonatal Inpatient Progress Sheet 100030, 16.3.11, Social Work.
[56] Exhibit 1, Tab 32, p. 5.
[57] Exhibit 1, Tab 34, p. 1.
[58] Exhibit 1, Tab 35, p. 2.
[59] Exhibit 1, Tab 34, p. 3.

well bonded with Baby Z and he had no concerns that she might present an acute risk to Baby Z's safety.[60]

48. That same day Baby Z was discharged from the Special Care Nursery to the ward, to be cared for by his mother.[61] It was explained during the inquest that this was an opportunity to test whether Baby Z's mother was actually able to care for Baby Z, outside of the artificial environment of the nursery.[62] Ms Byrne at DCP was notified by Ms Staines of Baby Z's discharge to the ward and that his mother was likely to be kept in hospital until Monday to ensure her pain was under control. Ms Byrne emailed back to seek confirmation that hospital staff would be monitoring Baby Z's mother over the weekend to ensure she was providing safe and appropriate care to Baby Z, which Ms Staines confirmed would occur.[63]

49. Overnight on 17 to 18 March 2011 Baby Z's mother was cared for by Clinical midwife Dorothy Hope. Midwife Hope noted that Baby Z's mother had difficulty with time management and was resistant to regular feeds for Baby Z. She noted that Baby Z's mother was very drowsy during the night, had to be woken for feeds and was constantly nodding off to sleep again.[64]

50. On Friday, 18 March 2011 Baby Z's mother's wound was found to be healing well and she did not have a fever. Her epidural was also removed that day. There was some initial thought by the reviewing medical team in the morning that she might be fit for discharge but then the midwife raised concerns that Baby Z's mother still needed some assistance with certain tasks in caring for Baby Z.[65] The medical team at that stage did not seem to be particularly concerned about reports of her continued drowsiness, although the nursing notes recorded that she was still nodding off while holding her baby.[66]

51. Dr Hamilton was aware that Baby Z's mother's continued drowsiness had prompted a Senior Registrar and midwife to comment that Baby Z's mother's mothercrafting skills needed to be observed before she could safely return to Bandyup with Baby Z. Dr Hamilton reviewed Baby Z's mother after the earlier medical round and made a note that she must stay in over the weekend for reduction of her pain medication and was not to be discharged back to Bandyup until her pain relief was reduced to paracetamol and ibuprofen only. Her regular diazepam was ceased at this time.[67]

52. Ms Staines had a discussion with Baby Z's mother on Friday, 18 March 2011 about the plans for her to go to a residential program called

[60] Exhibit 1, Tab 34, p. 3.
[61] Exhibit 1, Tab 32, p. 5 – 6.
[62] T 40.
[63] T 243 – 244; Exhibit 2, Tabs 1.3 and 1.4.
[64] Exhibit 1, Tab 40.
[65] Exhibit 1, Tab 31 [9] – [10]; Exhibit 6, Tab 2, Integrated Prgress Notes 100197 – 100198.
[66] Exhibit 1, Tab 31 [10] – [12].
[67] Exhibit 1, Tab 32, p. 6; Exhibit 6, Integrated Progress Notes 100199, 18.3.11.

Saranna Women's Program run by Cyrenian House after release from prison. Baby Z's mother indicated she was keen to comply with the plan and told Ms Staines that Baby Z was her "hope for the future."[68]

53. Registered Midwife and Nurse Linda Stretch also spoke to Baby Z's mother on 18 March 2011. They discussed the importance of sleep for her health and wellbeing and to be able to care for Baby Z safely. She also addressed the issue of co-sleeping and the dangers of this practise and gave Baby Z's mother a leaflet to read about co-sleeping.[69]

54. Dr Rolland Kohan, a Consultant Neonatologist at KEMH, was involved in a review of Baby Z in conjunction with the Paediatric RMO, Dr Zoe Wake, on 18 March 2011 due to the "complex social circumstances"[70] involved in the case. Dr Wake was still a paediatric trainee and this was her first experience of a baby born to a serving prisoner. Dr Wake was aware that with the weekend coming there was the possibility of discharge so she sought the advice of Dr Kohan after reviewing Baby Z's mother in the morning.[71]

55. Dr Kohan understood from Dr Wake that there was concern from the midwifery staff and the social work department that Baby Z's mother was not attending to Baby Z's needs, such as keeping him regularly fed and dressed to stay warm.[72] A note had been made by a nurse shortly before the review that Baby Z's mother was also still occasionally dozing off while holding her baby.

56. Dr Kohan made a plan that Baby Z was not to be discharged until Baby Z's mother was off her pain medications and it was felt by the KEMH midwives and social workers that Baby Z's mother was able to care for him.[73] There was no concern that Baby Z himself was unwell at that stage although there was a concern that he wasn't being offered enough milk and, as a result, wasn't thriving.[74] Dr Kohan recalls that Baby Z was "definitely improving"[75] and there were no long term concerns about him or any suggestion he would have greater than normal needs for follow-up after discharge.[76] The main concern was simply to ensure that Baby Z's mother could meet his needs, which was the domain of the social workers and DCP staff.[77]

57. Registered midwife Hang Ta was caring for Baby Z's mother that afternoon and evening and she noted that Baby Z's mother appeared to be agitated as the day progressed and showed frustration when Baby Z wouldn't settle. However, Midwife Ta attributed her frustration to the fact that her missing fingers made it difficult to perform care tasks for

[68] T 207; Exhibit 1, Tab 63 [34].
[69] Exhibit 1, Tab 38 [11].
[70] Exhibit 6, Tab 1, Neonatal Inpatient Progress Sheet 100034, 18.3.11, 11.00 hrs.
[71] T 64.
[72] T 38 – 39.
[73] Exhibit 1, Tab 33, p. 2; Exhibit 6, Tab 1, Neonatal Inpatient Progress Sheet, 18.3.11, 14.45 hrs.
[74] T 38 – 39, 43.
[75] T 37.
[76] T 38, 42.
[77] T 39, 42.

the baby quickly, which caused Baby Z to continually cry. Baby Z's mother's frustration appeared to be with the situation, rather than her baby.[78] Midwife Ta did not observe Baby Z's mother to be especially drowsy.[79]

58. During her shift Midwife Ta found Baby Z in bed with his mother, who was asleep with Baby Z at her breast. The bed rail was down and a thin top sheet was covering Baby Z. Midwife Ta woke Baby Z's mother and advised her about using the bed rail and told her not to cover the baby's head and face with the bed sheet due to the risk of suffocation.[80]

59. In the early hours of Saturday, 19 March 2011 Registered nurse and midwife Monica Rogan found a lighter secreted in Baby Z's mother's bed. The security staff were notified and they removed the lighter. Baby Z's mother was aggressive towards the security staff and Midwife Rogan after this time. She did not breastfeed Baby Z overnight and from 3.00 am to 6.00 am Baby Z was kept in the nursery as Baby Z's mother was considered too drowsy to hold and care for him safely. She had been found earlier sitting on the edge of the bed holding Baby Z but unable to keep her eyes open.[81] Baby Z's mother appeared to sleep for extended periods overnight.[82]

60. At 9.00 am on 19 March 2011 a Paediatric RMO, Dr Weeks, made a note of a discussion with a midwife who was very concerned about Baby Z's mother's care of Baby Z. The midwife indicated that Baby Z's mother's mood was very changeable and observed that Baby Z had been found in bed being breastfed by his mother with the side rail down and a sheet over his head (the incident described above witnessed by Midwife Ta). As well as being warned of the risk of possible suffocation at the time, Baby Z's mother was given more information about safe feeding positions later that day. The RMO made a note that both mother and baby must stay in over the weekend and be reviewed by social work the following Monday.[83]

61. The midwife co-ordinator, Clinical midwife Jo-Ann Lewis, was directly involved in Baby Z's mother's care that day as she felt the other staff were too junior for the task. Midwife Lewis had not looked after Baby Z's mother before, although she was aware of her patient history. Baby Z's mother was given 10mg of diazepam at midday and again at 3.00 pm. Baby Z's mother appeared very drowsy throughout the shift. She also aggressively refused to allow her wound to be checked.[84]

62. Midwife Lewis also found Baby Z's mother asleep in bed while breastfeeding Baby Z during the shift. She offered to put Baby Z in his cot and take him to the nursery so that Baby Z's mother could sleep

[78] Exhibit 1, Tab 27 [25] – [27].
[79] Exhibit 1, Tab 27 [30].
[80] Exhibit 1, Tab 27 [32] – [34].
[81] Exhibit 1, Tab 37; Exhibit 6, Tab 2, Integrated Progress Notes 100200, 19.3.11, 07.15 hrs.
[82] Exhibit 1, Tab 37; Exhibit 6, Tab 2, Integrated Progress Notes 100201, 19.3.11, 07.15 hrs.
[83] Exhibit 6, Tab 1, Neonatal Inpatient Progress Sheet 100036-37, 9.00 hrs & 10.25 hrs.
[84] T 142; Exhibit 6, Tab 2, Integrated Progress Notes 100201, 19.3.11, 13.00 hrs.

but Baby Z's mother became verbally aggressive. Midwife Lewis then decided to defuse the situation by leaving the room. She returned later when Baby Z's mother was asleep and put Baby Z in his cot. Midwife Lewis noted that Baby Z's mother continued to co-sleep with him despite being reminded of the dangers of co-sleeping and SIDS and being given information about safe sleeping habits.[85]

63. At 8.30 pm a note was made that Baby Z's mother was still very sleepy and had fallen asleep with her face in her dinner. She was reportedly not waking and attending to Baby Z's needs.[86] From what she observed, Midwife Lewis did not consider that Baby Z's mother was appropriately caring for Baby Z.[87] She was unwilling to engage with Midwife Lewis about the co-sleeping issue and showed a general unwillingness to correct her behaviour.[88] From what she saw at the time, Midwife Lewis did not think that Baby Z's mother's state of drowsiness and attitude towards co-sleeping could be remedied quickly.[89] However, at least in relation to her drowsiness and attention to Baby Z's needs, Midwife Lewis acknowledged that "[s]ometimes it's amazing what a good sleep will do"[90] and things may have improved over the following days.

64. At 11.00 pm Baby Z's mother was noted to have self-initiated breastfeeding of Baby Z and she breastfed him again at 12.30 pm with a top-up of formula. Mother and baby both then slept.[91] Baby Z's mother continued to complain of pain overnight and was given Tramadol in the early hours of the morning.[92] The Anaesthetic Pain Service conducted a round on the morning of Sunday, 20 March 2011 and indicated a reduction in her gabapentin as well as a change to her quetiapine to PRN or 'as required' basis.

65. The RMO, Dr Weeks, saw Baby Z's mother again on 20 March 2011 at 11.10 am and noted that she seemed to be showing appropriate care and concern for her baby and caring for him well, although she was still requesting pain relief and noted to be drowsy at times.[93]

66. In the early afternoon Baby Z's mother repeatedly sought more diazepam, which initiated a call to the Anaesthetic Pain Service. The Registrar of that Service declined to change the timing of the dose to allow her to have diazepam sooner than charted. Baby Z's mother was offered quetiapine, which she declined, and a review by the anaesthetist was requested although they were apparently in the operating theatre.[94]

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[85] T 145, 151; Exhibit 1, Tab 41 [8] – [13].
[86] T 142; Exhibit 6, Tab 2, Integrated Progress Notes 100201, 19.3.11, 20.30 hrs.
[87] T 143.
[88] T 146 – 150.
[89] T 144.
[90] T 150.
[91] Exhibit 6, Tab 2, Integrated Progress Notes 100202, 19.3.11, 2300 hrs and 20.3.11, 00.30 hrs.
[92] Exhibit 6, Tab 2, Integrated Progress Notes 100202, 20.3.11, 04.30 hrs.
[93] Exhibit 6, Tab 1, Neonatal Inpatient Progress Sheet 100037 – 38, 20.3.11, 11.10 hrs.
[94] Exhibit 6, Tab 2, Integrated Progress Notes 100203, 20.3.11, 4.20 hrs.

67. Overnight from 20 to 21 March 2011 Registered Midwife Barbara Barton was the primary staff member involved with Baby Z's mother. Midwife Barton had not had contact with Baby Z's mother before but she was aware from the handover when she started the shift that Baby Z's mother was a complex care patient. Given what she was told, Midwife Barton was conscious of the need to observe Baby Z's mother's mothercrafting skills and monitored the feeds and care of Baby Z closely overnight.[95]

68. During the night Baby Z's mother was noted to have slept but independently woke to feed Baby Z by breastfeeding with formula top-ups. No concerns were noted in her medical notes overnight.[96] Baby Z's notes record him as being settled between feeds. Midwife Barton indicated she had assisted with Baby Z's care earlier in the night as Baby Z's mother was very tired but Baby Z's mother had changed him herself at the 5.00 am feed on the morning of Monday, 21 March 2011.[97] Midwife Barton considered that Baby Z's mother handled Baby Z appropriately and although she was tired early in the night, she did not appear excessively drowsy.[98] At the end of her shift Midwife Barton had no particular concerns about Baby Z's mother's ability to care for Baby Z.[99]

DISCHARGE FROM HOSPITAL

69. Baby Z and his mother were discharged from hospital and transferred to Bandyup on the morning of Monday, 21 March 2011.

70. Dr Hamilton did not see Baby Z's mother again prior to her discharge and Baby Z's mother was not reviewed by another Consultant Obstetrician.[100] Dr Hamilton gave evidence that she had been hoping to see Baby Z's mother that day, before she was discharged, but Dr Hamilton had a commitment in the morning and by the time she had finished with that commitment Baby Z's mother had already left the hospital.[101] Dr Hamilton had not written in the medical notes that she wanted to see Baby Z's mother again before her discharge, so the other medical staff were unaware of her intention and followed the standard discharge procedure. Dr Hamilton explained that she would have liked to have seen Baby Z's mother in order to satisfy herself that everything had been sorted out and that Baby Z's mother was no longer as drowsy and had been looking after her baby appropriately.[102]

71. What instead occurred was that the Blue Team Registrar reviewed the deceased on the morning ward round. It was noted that the deceased

[95] T 154.
[96] Exhibit 6, Tab 2, Integrated Progress Notes 100203, 20.3.11 – 21.3.11.
[97] Exhibit 6, Tab 1, Neonatal Patient Progress Sheet, 100038.
[98] T 154 – 155.
[99] T 158.
[100] T 136.
[101] T 132 – 133.
[102] T 133, 137.

was feeling well and her pain was under control. The Registrar indicated that she could go home that day if she felt well and Baby Z had been checked. The discharge was then arranged by the Blue Team Resident Medical Officer (RMO), Dr Subashini Valayutham, in accordance with those instructions. That was the only day that Dr Valayutham was directly involved in Baby Z's mother's care as it was the first day of his rotation on the Blue Team.[103]

72. Dr Valayutham was not aware of any concerns regarding the ability of Baby Z's mother to care for her baby but he states that if there were serious concerns he would have expected the nurses or nursing coordinator to inform the medical team. He does not recall Baby Z's mother being drowsy when she was reviewed by the Registrar and if she had been drowsy, it would have been his practice to record that in the notes. Instead, he noted that she was "[f]eeling well," which indicates that she was speaking to them.[104]

73. The primary focus of the Blue Team's review and discharge instructions was her wound care.[105] Pending a baby-check by the paediatric team, Baby Z's mother was discharged from KEMH by Dr Valayutham on paracetamol, ibuprofen and her usual methadone dose of 60mg. She was also prescribed:

- pantoprazole for gastric acidity while on the ibuprofen;
- frusemide for her oedema;
- gabapentin, down to 1 tablet at night for 5 days as the end of the reducing regime;
- quetiapine for agitation;
- tramadol for pain relief;
- augmentin duo forte for a further three days to complete the course of antibiotics; and
- iron tablets.[106]

She was not prescribed diazepam and there was a specific note by Dr Valayutham that she was 'not for diazepam' on discharge.[107] The main direction on discharge was in relation to her wound care.[108]

74. Having reviewed the medical notes, Dr Pavy gave evidence that the reduction in Baby Z's mother's pain medications would have improved her state of alertness. Noting that her liver would have been capable of processing the drugs quickly, Dr Pavy observed that her state of alertness would not have been likely to deteriorate from there unless something else occurred.[109]

[103] T 136, 162 – 164; Exhibit 4, Tab 2A and Tab 2B; Exhibit 6, Tab 2, 100203 – 100204.
[104] T 169; Exhibit 4, Tab 2B [26].
[105] T 165.
[106] Exhibit 1, Tab 32, p. 6; Exhibit 4, Tab 2.
[107] T 166; Exhibit 1, Tab 2, Integrated Progress Notes, 100204, 21.3.2011.
[108] Exhibit 6, Tab 2, 100005.
[109] T 236 – 237, 239.

75. Baby Z was reviewed that morning by the Paediatric RMO and a note made that he was ready to be discharged from a medical point of view, although social work still needed to review his case. Baby Z had made significant weight gains over the last few days, which was a reassuring indicator that his feeding needs were being met.[110] The note also indicated that Baby Z's mother was interacting appropriately with Baby Z at that time.[111] A later note was made by a midwife that Baby Z's mother was caring for Baby Z independently.[112]

76. Ms Staines made a note in Baby Z's mother's medical record on 21 March 2011 sometime after the Anaesthetic Pain Service Round at 9.15 am. Ms Staines' note indicated that Baby Z's mother had been reviewed by social work and cleared for discharge that day.[113]

77. Ms Staines had been visiting Baby Z's mother regularly on the ward and she recalls seeing a noticeable improvement in her level of drowsiness after her surgery.[114] She also observed Baby Z's mother's interaction with her baby and as far as she could see "there was nothing at fault with her caring capacity"[115] and she recalled that the nurses reported that Baby Z's mother was appropriate in the way she was managing with Baby Z.[116]

78. Ms Staines indicated in her statement that at the time of her review on 21 March 2011 she was satisfied from a social work perspective that Baby Z's mother was fit for discharge with Baby Z and was able to care for him because:

- she had been liaising with DCP and knew there was a plan in place for mother and baby at Bandyup where Ngala would provide support;
- there was a plan in place after her prison release to go to Saranna;
- she had observed Baby Z's mother's interactions with Baby Z on the ward and they were appropriate;
- she had spoken to nursing staff on the ward and they did not express any concerns; and
- she was of the opinion that Baby Z's mother's drowsiness had improved.[117]

79. Ms Staines could not recall specifically whether she actually visited Baby Z's mother the morning of her discharge as part of the review, although that was her usual practice. The fact she made a note in Baby Z's mother's medical file on 21 March 2011 would also suggest that she did.[118]

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[110] T 43.
[111] Exhibit 6, Tab 1, Neonatal Inpatient Progress Sheet 100038, 21.3.11.
[112] Exhibit 6, Tab 1, Neonatal Inpatient Progress Sheet 100038, 21.3.11.
[113] Exhibit 1, Tab 63 [48].
[114] Exhibit 1, Tab 63 [37].
[115] Exhibit 1, Tab 63 [44].
[116] Exhibit 1, Tab 63 [45].
[117] Exhibit 1, Tab 63 [48] – [53].
[118] T 212 – 214.

80. In her oral evidence at the inquest Ms Staines was asked whether she was aware of the notes made by nursing staff over the previous weekend, in particular the notes about Baby Z's mother being drowsy and not waking for Baby Z's needs, when she conducted her final review. She replied, "I do not believe I was aware of that."[119] Ms Staines indicated that she would be surprised if she had reviewed the notes and read those statements and not acted upon it, noting that it would be unusual behaviour for her to do so.[120] Ms Staines also agreed that in hindsight, if she had known that information it might have affected her decision.[121]

81. Nevertheless, Ms Staines said she was also relying in her decision-making upon her own assessment of Baby Z's mother's mothercrafting skills, which she had seen first-hand during daily visits on weekdays. Ms Staines had observed Baby Z's mother to be very responsive and caring with Baby Z and she had always spoken very positively about her future plans for him.[122]

82. I note that in a statement provided by Mr Neil Boardley, the current Executive Director of Midwifery, Nursing and Patient Support Services at KEMH, he states that social workers are not responsible for assessing mothercrafting, and that is the role of the midwives, who are caring for the mother around the clock.[123] In that sense, Ms Staines inclusion of her own assessment of Baby Z's mothercrafting skills in her decision-making would seem to be at odds with hospital policy. However, I note that Ms Staines also indicated that she had spoken to nursing staff, who had expressed no concerns, so I don't think much turns on the matter.

83. At the time Baby Z was discharged and sent to Bandyup with his mother no decision had yet been made by DCP about whether or not statutory action would be undertaken.[124] The usual practice was apparently for a post birth meeting to occur between DCP and KEMH staff prior to discharge. However, in this case a post birth meeting did not occur.[125]

84. Further, neither DCP nor the Crisis Care Unit were notified of the decision to discharge Baby Z and allow him to go to Bandyup with his mother prior to the discharge taking place.[126] Ms Staines' evidence was that she believes it was something she simply overlooked that morning rather than a deliberate choice not to notify DCP.[127] I note that

[119] T 211.
[120] T 212.
[121] T 211.
[122] T 219 – 220.
[123] Exhibit 10 [37] – [42].
[124] Exhibit 2, Tab 1, p. 4.
[125] Exhibit 2, Tab 1, p. 4.
[126] Exhibit 2, Tab 1, p. 4.
[127] T 217.

Ms Staines had foreshadowed the possibility of a Monday discharge with DCP in an email on 17 March 2011.[128]

85. The first time that DCP became aware that a definite decision had been made to discharge Baby Z with his mother to Bandyup was when Ms Byrne rang KEMH Social Work Department during the afternoon of Monday 21 March 2011. She was told by another KEMH social worker, not Ms Staines, that Baby Z and his mother had already been discharged at 12.30 pm and returned to Bandyup.[129]

86. Ms Byrne agreed that she was surprised that she had not been notified prior to the discharge, even though it had been flagged as a possibility for the Monday. If she had been notified in advance, she indicated she would have sought an update as to the medical staff's observations of Baby Z and his mother over the weekend and their assessment of her condition, her drowsiness and her ability to care for Baby Z.[130]

87. However, Ms Byrne acknowledged during the inquest that if she had been told the summary of what is now known of the observations of Baby Z's mothercrafting over the weekend, she didn't know if that information would actually have changed the decision to continue working with a safety plan with Baby Z's mother in Bandyup. It might simply have indicated that the next Signs of Safety meeting should be arranged as a higher priority.[131]

88. Having found out about the discharge, Ms Byrne emailed Ms Staines at 4.03 pm that same day and asked in the email whether there were any ongoing health concerns for Baby Z or his mother that would need to be considered in the next Signs of Safety meeting.[132] Ms Staines did not respond until the following morning and in her email she indicated that Baby Z was doing well and had no ongoing health concerns, but did not address Ms Byrne's query in relation to Baby Z's mother.[133] Ms Byrne accepted in her evidence that it would have been prudent to follow up the further information she had requested about Baby Z's mother with Ms Staines, but it seems she simply overlooked it at the time.[134]

89. Ms Byrne then went about the process of trying to organise the second Signs of Safety meeting.[135] It was eventually scheduled for Monday, 4 April 2011, but sadly Baby Z passed away the day before.[136]

BANDYUP PRISON MOTHER/BABY SERVICES

[128] T 196.
[129] Exhibit 1, Tab 43 [35].
[130] T 244.
[131] T 247.
[132] Exhibit 2, Tab 1.4.
[133] Exhibit 2, Tab 1.4.
[134] T 248.
[135] T 249; Exhibit 1, Tab 43 [38].
[136] Exhibit 1, Tab 43 [38].

90. The placement of children and babies with their mothers in Western Australian prisons has been occurring since the early 1970's. There is no legislation specific to WA prisons directly relating to the residential placement of children but there are various Department of Corrective Services (the Department) policies and procedures in place and ongoing arrangements with other agencies such as DCP.[137]

91. Children are permitted to reside in Bandyup with their mothers in limited circumstances with the approval of the Superintendent under the provisions of the Department's Child Residence Program.[138] The purpose of the program is "the maintenance or establishment of the bonds and relationships between mothers and their children"[139] and is approved where it is considered to be in the best interests of the child and the management and security of the prison is not threatened.[140]

92. If there are child protection concerns and the DCP is involved in the case, approval must first be obtained from DCP before the Superintendent can permit the child to reside in prison.[141] Similarly to the Department, from the perspective of DCP, "[t]he placement of children with mothers in a prison environment aims to maintain the parent-infant relationship while the mother is incarcerated. The primary decision-making consideration is the best interests of the child and whether these can be met in the context of the prison environment."[142] There is a Memorandum of Understanding between DCP and the Department as to the processes involved.[143]

93. When a prisoner is permitted to have her child reside with her in custody, the mother is expected to assume full responsibility for the child's care and safety while residing in prison. However, the Department also accepts that it continues to owe a duty of care to the child and provides services within the prison to promote the safety and wellbeing of the child.[144] The Department also acknowledges that the standard of care required to be provided to the child is high.[145] If any Departmental staff have any concerns regarding the well-being of a child in the prison they are directed to report and document their concerns to the Superintendent of the prison immediately.[146]

94. House 9 and 10 in Unit 5 at Bandyup, which are collectively known as the Nursery Unit, house inmates who are either pregnant or have babies resident with them. In order to allow the mothers to care for their children the Nursery Unit is set up differently to other prison units and is designed as a "Drug Free Living Unit separate from the

[137] Exhibit 4, Tab 1, Directed Review, p. 6, 16.
[138] Exhibit 4, Tab 1.7, p. 2.
[139] Exhibit 4, Tab 1.7, p. 2.
[140] Exhibit 4, Tab 1.7, p. 2.
[141] Exhibit 4, Tab 13.
[142] Exhibit 2, Tab 1, p. 5.
[143] Exhibit 4, Tab 1.13.
[144] Exhibit 4, Tab 1.7, p. 3.
[145] Exhibit 4, Tab 1.7, p. 3.
[146] Exhibit 4, Tab 1.7, p. 11.

mainstream of the prison."[147] The mothers and their children reside in a communal house with shared facilities, including a kitchen, living area and enclosed play area.[148] The prisoners' rooms are not locked at night other than in an emergency situation,[149] so the mothers can access the kitchen and living areas overnight.

95. A Senior Child Protection Worker from DCP is based at Bandyup and funded by the Department of Corrective Services. The role is known as the Senior Family Links Officer. The officer is essentially responsible for overseeing child protection issues. In Bandyup the role involves working with any women who have open DCP case files and acting as a liaison between the women and the DCP case officers, as well as maintaining a flow of information between the Department of Corrective Services and DCP. The functions of the officer are set within the framework of the Department's guidelines and policies as well as child protection legislation. The current worker had been employed in the relevant position for 18 months in May 2010 and works out of Bandyup two to three days a week, depending on the workload.[150]

96. Another service available to mothers at Bandyup is a parenting advice and support service provided by Ngala via a contract with the Department of Corrective Services. Two Ngala workers are based at the prison. One works as an Early Childhood Educator and in her role she provides an early childhood programme to the mothers in the Nursery Unit at Bandyup, including advice and support about feeding and sleeping. She also attends the Sign of Safety meetings with the mothers as their support person, if they request it.[151] Another Ngala worker is a social worker and provides parenting support and education to women in the mainstream section of the prison.[152]

97. Ngala staff can also perform an assessment of mothers when requested by DCP, but this is done by a multi-disciplinary team and not the usual Bandyup-based Ngala staff.[153]

98. The babies of mothers in prison are not generally considered the primary responsibility of the prison's Health Services staff, although the Health Services nursing staff will examine the child at the time of admittance to prison to ensure there are no serious concerns for the child's well-being/health.[154] If the child is sick then they will not be permitted to stay in the prison until they have been medically cleared. If a child residing in prison becomes sick while in prison then Health Services staff are required to ensure the child receives appropriate

[147] Exhibit 4, Tab 1.9, p. 6.
[148] Exhibit 5, Tab 1.9.
[149] Exhibit 4, Tab 1, Directed Review, p. 5.
[150] Exhibit 1, Tab 44 [3] – [7]; Exhibit 4, Tab 1, Directed Review, p. 8 and Tab 1.10.
[151] T 280 – 281; Exhibit 1, Tab 47.
[152] T 280 – 281; Exhibit 1, Tab 48 [8] – [9].
[153] Exhibit 1, Tab 48 [18].
[154] Exhibit 1, Tab 7, p. 10 and Exhibit 4, Tab 1.32.

medical care until arrangements can be made for the child to leave the prison in order to receive the medical attention they need.[155]

99. The Health Services staff also notify the local Community Child Health Nurse who is encouraged to attend at the prison to review the care of the child and offer advice to the mother.[156] The Child Health Nurse usually attends Bandyup once a fortnight.[157]

100. The Department follows the State Health Department guidelines on co-sleeping, acknowledging it is not a safe practice, particularly in a prison where there are only single beds. Accordingly, the practice is discouraged by prison staff. If the behaviour is observed it is addressed by education, in the first instance, but can result in eviction from the Nursery unit if the behaviour persists.[158]

BABY Z'S HEALTH AND CARE AT BANDYUP

101. Mr Schober-Rowe, the DCP Family Links Officer at Bandyup, had not attended Baby Z's mother's initial Signs of Safety meeting although he had been aware of it being planned and the general outcome of the meeting. After the meeting was held Mr Schober-Rowe was involved in getting approval from the Assistant Superintendent of Operations of Bandyup, Mr Michael Henderson, for a Residential Application for Baby Z to allow him to reside with his mother at Bandyup after his birth.[159] Mr Schober-Rowe was on leave at the time Baby Z and his mother were discharged from KEMH to Bandyup and did not return from leave prior to Baby Z's death, so he had no direct involvement with Baby Z or Baby Z's mother at the relevant time.[160]

102. A Child Care Plan was also created in relation to Baby Z, although due to an oversight it was not finalised or signed by Baby Z's mother.[161]

103. Ms Georgina Akers (as she then was), was the Ngala Early Childhood Educator at Bandyup in 2011. She had met Baby Z's mother prior to the birth of Baby Z and attended the first Signs of Safety meeting with her. Baby Z's mother also participated in a four week parenting programme run by Ms Akers, which included information on the effects of parents behaviour on children, protective behaviours of children and the right to feel safe.[162] Ms Akers' recollection was that Baby Z's mother was very happy and excited about her pregnancy and what the future might bring for the new baby and her family.[163]

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[155] T 267 – 268; Exhibit 1, Tab 4, p. 10 and Tab 8; Exhibit 4, Tab 1.32.
[156] Exhibit 1, Tab 4, p. 10; Exhibit 4, Tab 1.32.
[157] T 266.
[158] T 269 – 270, 278 – 289.
[159] Exhibit 1, Tab 44.
[160] Exhibit 1, Tab 44.
[161] Exhibit 4, Tab 1, Directed Review, p. 10, 13 and Tab 1.22.
[162] T 287; Exhibit 1, Tab 44 [14] – [15].
[163] T 287.

104. Once Baby Z's mother went to KEMH to have her baby, Ms Akers kept in contact with KEMH and DCP social workers and was included in the planning for the second Signs of Safety meeting, which was later postponed. After Baby Z's mother returned to Bandyup Ms Akers saw her on a couple of her visits to the Nursery Unit. She assisted Baby Z's mother in filling in some paperwork and also spoke to her a few times about breast and bottle feeding. She noted that Baby Z's mother was "appropriately besotted"[164] with Baby Z and she had no concerns about Baby Z's mother's care of Baby Z from what she observed.[165] At the time Ms Akers had contact with Baby Z's mother, Baby Z's mother did not appear drowsy.[166]

105. On one of these visits, on 28 March 2011, Ms Akers watched over Baby Z briefly whilst Baby Z's mother went to the bathroom. At that time Ms Akers noticed that Baby Z was breathing quite heavily. She asked Baby Z's mother if his breathing was normally that laboured and Baby Z's mother appeared unconcerned and attributed it to the fact he had been crying earlier. Prior to leaving the Nursery Ms Akers checked on Baby Z and his breathing appeared to have returned to normal so she was reassured. This was the last time she saw Baby Z.[167]

106. Baby Z's mother stated that Baby Z was feeding really well after they returned to Bandyup together. He was breastfed and also given formula on occasion.[168] Baby Z apparently would wake up one or two times a night and his mother would breastfeed him on those occasions. She admitted that on a couple of occasions she fell asleep while feeding him in her bed. She stated that she was worried that if she was caught with him in her bed she could be thrown out of the Nursery unit, which indicates she was well aware of the DCP policy prohibiting co-sleeping.[169]

107. Baby Z's mother had noticed when Baby Z was still in hospital that he would breathe rapidly when moved. Once they were at Bandyup she observed he would still breathe fast sometimes but his breathing would then settle back down.[170]

108. A friend of Baby Z's mother, Ms Buller, often saw Baby Z's mother during the day, although she was housed in a different unit. On two occasions Ms Buller thought she also observed Baby Z exhibiting breathing issues. The first time was one afternoon not long after Baby Z had arrived at Bandyup. Ms Buller was looking after Baby Z while his mother went to the office. Baby Z was sleeping soundly, lying on his back in his pram, when Ms Buller observed that his chest movement had stopped. She leant forward and touched him on the thigh. He appeared to startle and began breathing again, although the breathing

[164] T 289.
[165] T 289.
[166] T 291.
[167] T 289; Exhibit 1, Tab 47 [21] – [31].
[168] Exhibit 1, Tab 8 [34] – [35].
[169] Exhibit 1, Tab 8 [37] – [39].
[170] Exhibit 1, Tab 8 [40].

seemed ragged. She called over another inmate and while they watched him he appeared to stop breathing again twice. When Baby Z's mother returned Ms Buller told her what she had seen and Baby Z's mother reassured her that he had been born with breathing problems but the KEMH staff had told her he was fine. Nevertheless, Baby Z's mother told her she would take him to see the nurses and walked towards the Health Centre. However, it does not appear that she actually attended the Health Centre that day.[171]

109. A few days later Ms Buller cared for Baby Z again for a brief time. She held his hand and watched him and thought she saw him stop breathing again. She placed her hand on his chest and felt there was no movement. She then touched his side and he startled and began breathing again, still in a way she described as "ragged."[172] Ms Buller told Baby Z's mother when she returned and Baby Z's mother told her she had been to see the nurses and they had told her it was nothing to be concerned about.[173]

110. Baby Z's mother makes no mention of these conversations with Ms Buller in her statement and interview and there is no record of Baby Z's mother attending the health centre and having such a conversation with a nurse.

111. There are only two references to Baby Z being seen at the health centre and neither one involved a discussion about breathing problems. Baby Z was seen at the health centre with his mother on 21 March 2011, at which time he was described as breastfeeding and hungry and appeared to be well, with a weight of 3900g (still 105g less than his birth weight).[174] On 26 March 2011 Baby Z's mother again attended the health centre with Baby Z. The main purpose of the visit was for her wound dressing to be changed but she also raised a concern about Baby Z having conjunctivitis in his left eye. She was given some information on conjunctivitis and advised by the clinical nurse to do eye toilets and given some saline sachets and cotton wool balls for this purpose.[175] She did attend the health centre on her own on other occasions, but there is no mention of a discussion about her baby's breathing on those occasions.[176]

112. A Community Health Nurse, Registered Nurse Sharon Karsakis, visited Bandyup on 31 March 2011 and attended House 9. She was introduced to Baby Z's mother, who appeared happy and excited by Nurse Karsakis' visit. Nurse Karsakis had read Baby Z's mother's notes before the visit and was aware that she took daily methadone but she did not appear to Nurse Karsakis to be under the influence of any drugs that day. Nurse Karsakis weighed Baby Z naked and noted at that time his skin appeared slightly mottled. Baby Z's mother told Nurse Karsakis

[171] Exhibit 1, Tab 13 [17] – [31].
[172] Exhibit 1, Tab 13 [32] – [39].
[173] Exhibit 1, Tab 13 [32]
[174] Exhibit 1, Tab 50; Exhibit 3, Tab 10, page 13 – 14.
[175] Exhibit 3, Tab 10, p. 11.
[176] Exhibit 1, Tab 10.

that his skin had always been like that, and Nurse Karsakis was aware that newborn babies of mothers on methadone can be mottled in appearance, so she was not concerned.[177]

113. Nurse Karsakis also noticed that Baby Z had a slight discharge from his eyes, which Baby Z's mother said he had caught in the nursery (although I note he had also had an ongoing issue with discharge from his eyes while at KEMH). Nurse Karsakis advised her to take him to the health centre if it worsened. Other than those issues Baby Z appeared alert and content with acceptable muscle tone and reflexes. She noticed he also made good eye contact with his mother.[178]

114. Nurse Karsakis asked if he was feeding and sleeping well and was informed that he was breastfeeding on demand and being given formula and he was sleeping well. Nurse Karsakis spoke to Baby Z's mother about the hazards of co-sleeping during this discussion.[179]

115. Nurse Karsakis asked Baby Z's mother if she had any other concerns about Baby Z, and she indicated she didn't. Nurse Karsakis did not notice any breathing irregularities with Baby Z during her examination and none were raised by his mother. At the end of her visit Nurse Karsakis had no concerns in relation to Baby Z or his mother's care of him. In her opinion Baby Z's mother appeared to be an attentive mother.[180]

116. A prison inmate, Ms Chadwick, who was housed with Baby Z's mother in the Nursery unit, described her as doting on Baby Z and "showing him off to everyone."[181] Ms Chadwick, who had three children and was pregnant with her fourth, also considered Baby Z's mother to be a "good mum,"[182] noting that she never let him cry for too long, fed him regularly and was attentive to some issues with his eyes. Ms Chadwick made an observation that Baby Z sounded a little like he had fluid on his lungs when he breathed, with a little rattle in his chest[183] and he had had "a bit of a snuffly nose" a week or two before he died,[184] but nothing that appears to have caused her to be overly concerned about him. She had also noticed that he used to sneeze a lot,[185] which was also noted by another inmate.[186]

117. Ms Chadwick did have some concerns about Baby Z's mother's health, in the sense that she "kept nodding off like she was drugged," usually in the middle of the day but sometimes at night, and Ms Chadwick was concerned it was due to Baby Z's mother being given both methadone

[177] Exhibit 1, Tab 45 [13] – [21].
[178] Exhibit 1, Tab 45.
[179] Exhibit 1, Tab 45 [33].
[180] Exhibit 1, Tab 45; Exhibit 5, Tab 1, Child Heath Visit 31.3.11.
[181] Exhibit 1, Tab 9, Statement 5.4.11 [19].
[182] Exhibit 1, Tab 9, Statement 5.4.11 [19].
[183] Exhibit 1, Tab 9, Statement 5.4.11 [19].
[184] Exhibit 1, Tab 9, Statement 5.4.11 [29].
[185] Exhibit 1, Tab 9, Statement 5.4.11 [30].
[186] Exhibit 1, Tab 12 [36] – [37].

and Seroquel (quetiapine).[187] One time, approximately a week before Baby Z died, Ms Chadwick heard Baby Z crying at night and went to check on him. She entered Baby Z's mother's room and found Baby Z's mother sitting on the floor near the end of her bed with Baby Z in her arms and her breast out to feed him but he wasn't feeding, just crying, and Baby Z's mother was asleep. She awoke when Ms Chadwick entered the room and then said that she was okay.[188]

118. Ms Chadwick had also seen Baby Z in bed with his mother several times and believed that Baby Z's mother sometimes co-slept with him but pretended she was feeding him because she was aware the Bandyup nursery policy does not allow co-sleeping.[189]

119. Ms Robinson, who was also living in House 9 at the relevant time, didn't remember anything out of the ordinary about Baby Z or his mother, although she does not appear to have been as close to her as Ms Chadwick and was also busy with her own newborn.[190] Like Ms Chadwick, Ms Robinson thought Baby Z's mother was a very attentive mother who took good care of him.[191]

120. The other inmate in House 9, Ms Monaghan, was also aware that Baby Z's mother took prescription drugs that would make her "sleepy."[192] She had not seen whether Baby Z's mother co-slept with Baby Z as she never went into her room at night. Ms Monaghan admitted to regularly co-sleeping with her own baby in the unit and noted she had only been caught by prison staff once, which was the night after Baby Z died.[193]

121. There was also some intelligence given to police that Baby Z's mother may have obtained Valium (diazepam) from another prisoner, although this was not pursued further given Professor Joyce's conclusions about the likely timing of when Baby Z's mother ingested the diazepam, based upon what was found in Baby Z's system.[194]

EVENTS OVERNIGHT ON 2 – 3 APRIL 2011

122. Baby Z's mother described everything as "ordinary"[195] during the day on 2 April 2011. Muster occurred in the unit at 6.30 pm, at which time the unit was locked down externally. Sometime around 6.45 pm, Baby Z's mother breastfed Baby Z and then put him into his cot on his side. She noted he was asleep and put a blanket on him.[196]

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[187] Exhibit 1, Tab 9, Statement 5.4.11 [35] – [43], [58].
[188] Exhibit 1, Tab 9, Statement 5.4.11 [43] – [45].
[189] Exhibit 1, Tab 9 [55] – [56].
[190] Exhibit 1, Tab 10, Statement 5.4.11 [21].
[191] Exhibit 1, Tab 10, Statement 5.4.11 [27].
[192] Exhibit 1, Tab 11 [16].
[193] Exhibit 1, Tab 11 [19] – [21].
[194] T 15 – 16. In addition, Dr Tim Pavy seemed to agree that the levels were consistent with Baby Z's mother's last hospital dose – T 238.
[195] Exhibit 1, Tab 8 [41].
[196] Exhibit 1, Tab 8 [42] – [43].

123. Afterwards they had dinner and Ms Chadwick, Baby Z's mother and another inmate then went into the bathroom. While they were sitting in the bathroom Ms Chadwick noticed that Baby Z's mother was "on the nod" and appeared to fall asleep while they were talking to her. Baby Z's mother mentioned how tired she was.[197]

124. Baby Z's mother gave various accounts of what happened from that time on, as set out in more detail below, but it was generally clear from her evidence and others that she bottle fed Baby Z sometime before midnight in the kitchen of the house and breastfed Baby Z again during the night and in the early hours of the morning she woke to find him cold and unresponsive. Baby Z's mother picked him up and called out for help, then ran out to the dining room and picked up the 'Cell Call' phone to ask for help. She recalls that no one answered on the other end. Baby Z's mother then called out and the other women in the unit came out to help her. She recalled trying to throw a chair at the window but most of the later events were a 'blur'.[198]

125. Ms Chadwick, heard Baby Z's mother screaming at a time she believed was approximately 4.00 am. She stated that she usually heard Baby Z crying about three times a night but she hadn't heard him cry that night.[199] Ms Chadwick came out of her room and saw Baby Z's mother place Baby Z on the kitchen bench. It was apparent to Ms Chadwick that he had died. Ms Chadwick recalls trying to call the prison guards on the unit's telephone and said she kept clicking as she was "stressing out, trying to get an answer."[200] She eventually hung up without speaking to anyone and called out through the open kitchen window for help.[201] Ms Monaghan then picked up the Cell Call phone and it was answered straight away.[202]

126. The Entry Control Officer for the evening, Glenn Johnson, had received the first call at approximately 3.30 am but had been unable to get a response from the prisoner on the phone and could only hear someone screaming hysterically and could also hear others in the background screaming as well. He had used his radio to contact the prison night rover officers and asked them to attend House 9 without knowing what was happening there. He then received the call from Ms Monaghan who asked that someone get there quick to help the baby, which he then relayed to the night rover staff.[203]

127. While waiting for the prison officers to attend Ms Robinson began performing CPR, which she had learnt when she had done a senior first aid course in Bandyup. She performed chest compressions on Baby Z

[197] Exhibit 1, Tab 9 [47] – [51].
[198] Exhibit 1, Tab 8 [48] – [52].
[199] Exhibit 1, Tab 9, Statement 3.4.11 [17], [20] – [23].
[200] Exhibit 1, Tab 9 Statement 3.4.11 [8].
[201] Exhibit 1, Tab 9, Statement 5.4.11 [66] – [69], [71].
[202] Exhibit 1, Tab 11 [31].
[203] Exhibit 1, Tab 17.

and gave him a couple of breaths during compressions but he did not respond and showed no sign of breathing or moving.[204]

128. The general impression of the inmates was that it took a long time for the prison officers to attend, with estimates of up to 30 minutes after the time Ms Monaghan spoke to someone on the phone.[205] The inmates accepted that the prison officers did their best to help when they arrived, but believed they had been too slow in attending. They saw the officers walking when they were approaching and told them to run, which some of the prison officers also recall.[206]

129. Prison Officer Julie Baker was on duty that evening and working as a night rover, which included responsibility for attending to cell calls from prisoners. At approximately 3.30 am she was in the Unit 2 staff area with Prison Officer Sharon Muller and the two other night rover staff when they received a phone call from Entry Control advising them that they were required at Unit 5, House 9. At that stage they were not told what was wrong.[207] The four night rover staff proceeded to House 9. While en route they were told by Officer Johnson that there was a problem with a baby and a nurse was required, so Officer Muller radioed the night nurse, Nurse Susan Maughan, to attend.[208] Another officer also stopped at the health centre to make sure the nurse was coming.[209] Nurse Maughan recalls she had been notified of the incident at about 3.30 am and then Office Denton came past and told her she needed to come to House 9. She left immediately to attend with Officer Denton.

130. When they approached the unit they could hear a lot of urgent shouting. Officer Baker looked through the window and saw Baby Z's mother leaning on the end of the kitchen bench with Baby Z in her arms and it was clear she was hysterical.[210] The prison officers could also see the other inmates were all in the living room and they spoke to the prison officers through the window and told them that Baby Z had died. At 3.33 am Officers Muller and Baker requested the other inmates to go back to their rooms so the officers could enter. Prison rules prevent them from entering the house until everyone is secure and the Officer in Charge is in attendance. Ms Robinson gave Baby Z back to his mother and got her a blanket before the inmates other than Baby Z's mother returned to their rooms, which were secured by Entry Control.[211]

131. Officer Wild was the OIC that night and he and Nurse Susan Maughan had arrived around the same time as the four night rover staff. They all

[204] Exhibit 1, Tab 10, Statement 5.4.11 [46] – [54].
[205] Exhibit 1, Tab 11 [34].
[206] Exhibit 1, Tab 19 [24] and Tab 21 [10].
[207] Exhibit 1, Tab 16 [9].
[208] Exhibit 1, Tab 16 [11] and 19 [23].
[209] Exhibit 1, Tab [14].
[210] Exhibit 1, Tab 15.
[211] Exhibit 1, Tab 15 [9] – [18], [32].

entered the house at 3.34 am.[212] Baby Z's mother was still hysterical at this stage. Nurse Maughan ran inside and took Baby Z from his mother, with some assistance from Prison Officer Muller. Nurse Maughan immediately noticed that Baby Z was floppy and cold and recognised that he was showing no signs of life. Officer Muller noted that his skin felt rubbery and was a yellowy-grey colour.[213] Nurse Maughan yelled to the officers to call an ambulance and ran to the medical centre with the baby. The request for an ambulance was relayed to the Entry Control Officer who rang triple zero at approximately 3.35 am. The ambulance was tasked to attend at 3.36 am.[214]

132. As Nurse Maughan was running to the health centre she was administering CPR to Baby Z. Nurse Maughan reached the health centre at approximately 3.35 am and once there she continued performing CPR with the assistance of Officer Muller until the ambulance arrived at approximately 3.55 am.[215]

133. The ambulance officers took over CPR and checked for signs of life but found none. There were instead signs he had been deceased for a while. They declared Baby Z life extinct at 3.58 am.[216] Baby Z was then dressed and wrapped up and given back to his mother so that she could spend a little time with him before he was taken to the mortuary.[217]

134. Police officers attended, including officers from Major Crime and the Forensic Crime Scene Unit, and commenced an investigation into Baby Z's death. They inspected House 9 and examined Baby Z and also interviewed Baby Z's mother and various other witnesses. No suspicious circumstances were identified in relation to his death.[218]

CAUSE OF DEATH

135. Dr Daniel Moss, a Forensic Pathologist, performed a post-mortem examination on Baby Z on 6 April 2011. Dr Moss' examination revealed an apparently normally developed male infant with no evidence of significant natural disease or injury to account for his death. Following the initial examination Dr Moss initiated extensive further investigations to assist him in trying to establish a cause of death.[219]

136. Microscopic examination of the major internal organs and tissues was essentially normal and histology found no features of myocarditis, pneumonia or other significant abnormality that would explain the

[212] Exhibit 1, Tab 15 [9] – [18].
[213] T 26.
[214] Exhibit 1, Tab 22 [5].
[215] Exhibit 1, Tab 18.
[216] Exhibit 1, Tab 22 [11] – [14].
[217] Exhibit 1, Tab 18.
[218] Exhibit 1, Tab 55.
[219] Exhibit 1, Tabs 2 and 3.

death. There was no sign of infection.[220] A report from the WA Newborn Screening Programme indicated no evidence of any inborn metabolic abnormalities that are usually tested for in a newborn.[221]

137. Neuropathology examination of the brain was performed by Dr Vicki Fabian, a Consultant Neuropathologist at Royal Perth Hospital. On macroscopic examination there was felt to be a probable gyral abnormality within the right frontal lobe. Otherwise the examination showed an infant brain with no significant abnormality. Microscopic examination of the brain showed a focus of cerebral subcortical nodular heterotopia in the right frontal lobe. The relationship between this abnormality and epilepsy is uncertain. The abnormality may be clinically silent or it may have the potential to cause a seizure.[222] Dr Moss explained at the inquest that seizures can vary from a very focal type affecting one part of the body to a full-blown tonic clonic seizure and no evidence is apparent in the post mortem examination to indicate whether a seizure occurred.[223] Accordingly, the significance of this neuropathology finding is unknown.

138. Dr Moss considered the possibility of co-sleeping contributing to the death, given the exact circumstances of the death are unclear in relation to the position of the deceased and whether he was, in fact, co-sleeping with his mother at the time of death. Dr Moss could not exclude co-sleeping and possible 'overlaying' as potentially contributing to the death.[224] Dr Moss explained at the inquest that there are rarely specific signs that can be found at autopsy that can rule out, or point to, overlaying as a likely cause of death. Dr Moss explained that the evidence was more likely to come from the history than from the autopsy findings.[225]

139. Toxicology analysis showed the presence of desmethyldiazepam in Baby Z's blood at a level of 0.02mg/L and methadone in the liver at a level of 0.04mg/L. Dr David Joyce is a Clinical Pharmacologist and Toxicologist who works as a specialist physician in the area of human drug therapy and human toxicology. Dr Joyce was asked to consider the toxicology findings to assist Dr Moss in determining whether the drugs found in his system at post mortem may have played a role in his death.

140. Dr Joyce concluded that the methadone most likely transferred to the deceased in the breast milk when he was fed.[226] It was also plausible that the desmethyldiazepam was transmitted from Baby Z's mother to Baby Z through breast-feeding some time prior to his death. Dr Joyce noted that the elimination of diazepam and its metabolites is

[220] T 81.
[221] Exhibit 1, Tab 3.
[222] Exhibit 1, Tabs 3 and 5.
[223] T 80 – 81.
[224] T 82; Exhibit 1, Tab 3.
[225] T 83; Exhibit 1, Tab 3.
[226] T 69; Exhibit 1, Tabs 52 and 53.

comparatively slow, although the exact rate of elimination of desmethyldiazepam in a neonate is not known.[227]

141. Dr Joyce indicated that methadone is approved in the USA for use by a breast-feeding mother (consistent with the evidence of Dr Kohan) and diazepam is regarded as "moderately safe" for the baby when taken in single dose by a breast-feeding mother and "possibly hazardous" when taken regularly.[228]

142. In Dr Joyce's expert opinion neither the methadone concentration, nor the desmethyldiazepam concentration, nor the combination of the two, would have any toxicity risk for an older child. He noted that infants, such as Baby Z, are very sensitive to sedating drugs but even so, he considered there appeared to be ample margin for safety in the low concentrations found in the blood and tissue.[229] Dr Joyce acknowledged that it was possible that the concentrations in combination could increase the risk of Sudden Infant Death Syndrome in a neonate but in his opinion the levels were so low they were unlikely to be a risk to anybody.[230] Dr Joyce maintained that view even in the context of the possibility of co-sleeping, in the sense that the low level of drugs present would not have increased the risk that the baby faced in that situation.[231]

143. Dr Joyce was also referred to the relevant witness statements of people who had observed Baby Z in Bandyup prior to his death. Dr Joyce did not consider that the witnesses were describing symptoms of sedation in Baby Z nor were there any findings in his assessment by the Community Health Nurse that might signal a recognisable drug effect on him.[232]

144. In conclusion, Dr Joyce was of the view that the drugs in the deceased's system did not provide an explanation, alone, for his sudden death.[233]

145. Dr Kohan and Dr Kennedy (an expert paediatrician I refer to below) were asked about the possible relevance of witnesses' reportedly seeing Baby Z stopping breathing on a couple of occasions. Dr Kennedy explained that in very small babies it is not unusual for them to have a very irregular breathing pattern that can concern relatives and friends when observed, although there is nothing medically untoward behind it.[234] Dr Kohan gave similar evidence that babies can have periodic breathing, and although it is not as common in term babies Baby Z did have some premature lung disease early on and could have been behaving a little bit like a pre-term baby. Dr Kohan explained that this type of periodic breathing is not known as a precursor to SIDS.

[227] Exhibit 1, Tabs 52 and 53.
[228] Exhibit 1, Tab 52, p. 8.
[229] Exhibit 1, Tab 52, p. 9.
[230] T 70; Exhibit 1, Tab 52, p. 9.
[231] T 71.
[232] Exhibit 1, Tab 54.
[233] T 77.
[234] T 101.

Dr Kohan indicated that colour changes would be a more significant sign, but they were absent in this case.[235] Dr Kohan proferred his opinion that, based on what is known, it "seems that whatever happened, happened fairly acutely that day."[236]

146. In the end, despite the forensic pathologist going to great lengths to try to exclude as many factors as possible, there were no findings that could positively account for the death. The cause of death must, therefore, remain unascertained.

MANNER OF DEATH

147. Baby Z's mother was spoken to on a number of occasions to try to get a clear account of what occurred on the night Baby Z died. Her version of events remained generally consistent, however she was uncertain as to the sleeping location and position of Baby Z at the time she found him unresponsive.

148. When she was first spoken to by prison officers Baby Z's mother apparently told prison staff that she had got Baby Z out of his cot.[237]

149. Baby Z's mother was next spoken to by Detective Sergeant Narelle Woods who asked Baby Z's mother to tell her exactly what happened when the call was made. Baby Z's mother stated that she was sleeping in her bed when she woke up and she sat up to check the baby. She put her hand into Baby Z's cot and noticed he felt cold. She then looked at him and saw he was on his back and his mouth was open. She was asked by Detective Sergeant Woods if it was possible that Baby Z was in bed with her. Baby Z's mother responded, "No, we're not allowed to sleep with the babies. I don't normally sleep with him, he was in his cot."[238] After relating more of what occurred she was asked again by Detective Sergeant Woods if it was possible Baby Z was in her bed and Baby Z's mother responded, "I don't normally sleep with him. We are not allowed to."[239]

150. She was next interviewed by a different police officer and a registered nurse in order to complete a standard questionnaire used in sudden infant death cases. Baby Z's mother was extremely emotional and distraught and was initially resistant to answering questions but she then calmed down and answered most questions without difficulty.[240] She advised that she stayed up after the early evening feed and went to bed after midnight, at which time Baby Z was still in his cot. She then stated that she woke and fed Baby Z one more time but was unsure if he was then placed back in the cot or in bed with her. She woke up at approximately 3.00 am to find Baby Z lying on his back, not moving

[235] T 49 – 50.
[236] T 51.
[237] Exhibit 1, Tab 59, p. 3.
[238] Exhibit 1, Tab 63 [21] – [25].
[239] Exhibit 1, Tab 63 [33] – [34].
[240] Exhibit 1, Tabs 46 and 59.

and cold. When questioned about whether Baby Z had been in her bed with her, or in his cot, immediately prior to that time, Baby Z's mother became aggressive. She was also quite drowsy, and told the nurse she had been given medication to calm her. She eventually told the nurse she couldn't remember where he was when she woke and found him unresponsive.[241]

151. In her witness statement that she signed on 11 April 2011 Baby Z's mother states that Baby Z woke for another feed before she went to bed. She did not know what time it was, but it was dark. She states that she breastfed him again, in her bed, then put him into his cot, swaddled him and tucked a blanket into each side. She then states that she woke up and checked on Baby Z. She touched him and he felt cold.[242] During the interview to prepare that statement Baby Z's mother was described as "difficult to deal with and reluctant in answering questions, particularly when she perceived them to be confronting."[243] Sergeant Donkin explained further at the inquest that when he tried to establish with Baby Z's mother whether Baby Z had been in his cot, Baby Z's mother became extremely distraught and began yelling and screaming. She was also extremely evasive and defensive. However, what Sergeant Donkin was able to establish with Baby Z's mother was that she denied co-sleeping with Baby Z that evening.[244]

152. Ms Chadwick, who was friendly with Baby Z's mother, spoke to Baby Z's mother in the days after his death. Baby Z's mother was crying and told Ms Chadwick that she didn't know whether Baby Z had been in her bed or her cot that night.[245]

153. Another inmate, Ms Hoy, who was very close with Baby Z's mother, also spoke to her the day after Baby Z died and asked her whether Baby Z was in her bed or in his cot. She told Ms Hoy at that time that "he must have been in the cot because she remembers pulling him out of the blankets and he was cold."[246] However, Ms Hoy asked her again over the following days whether Baby Z had been in his cot and Baby Z's mother told her that "she couldn't remember where he was when she found him cold and not breathing."[247]

154. The evidence overall suggests that, rather than deliberately lying to police, with a knowledge that Baby Z was not in his cot that night, Baby Z's mother has no clear recollection of what occurred that night.

155. As to other evidence that might assist in this regard, Officer Muller's evidence was that she conducted a check through the viewing hatch of Baby Z's mother at 10.07 pm on the evening of 2 April 2011, at which time the light in the room was on and Baby Z's mother was up and

[241] Exhibit 1, Tab 46 [22] – [25], [30] – [32].
[242] Exhibit 1, Tab 8 [47] – [51].
[243] Exhibit 1, Tab 1, p. 15.
[244] T 14.
[245] Exhibit 1, Tab 9, Statement 5.4.11 [87] - [88].
[246] Exhibit 1, Tab 12 [57] – [58].
[247] Exhibit 1, Tab 12 [61].

moving around her room. She does not recall if she observed Baby Z at that time but could see that he wasn't on the bed. She thought Baby Z's mother probably had him with her and may have been changing him.[248]

156. At approximately 1.50 am Officer Muller conducted another check of Baby Z's mother's room. Officer Muller turned the light on briefly and saw Baby Z's mother sitting on her bed. "She was hunched forward and appeared to be asleep."[249] Again, Officer Muller couldn't see Baby Z but could see that he wasn't in the bed. Officer Muller indicated it was possible that Baby Z was in his mother's arms as she couldn't see well as her vision was obscured by Baby Z's mother's position, although she thought it was unlikely given the angle that she could see was such that she would have expected to have seen the baby in those circumstances. He might also have been in the cot.[250] At that time, the priority of the prison officers was to check on the mothers and to make sure the baby wasn't in the bed with the mother but they were under no general obligation to sight the baby.[251]

157. As noted above, the findings from the post mortem examination could not exclude co-sleeping as a possible contributor to the death but that conclusion came more from the history given than any specific post mortem findings.

158. There was general evidence that Baby Z's mother had been seen asleep in bed with Baby Z at KEMH and that she had been counselled about the need to engage in safe sleeping practices but seemed unwilling to engage with nursing and midwifery staff about the matter. There was also some evidence from other prisoners at Bandyup suggesting Baby Z's mother had continued to co-sleep with Baby Z on occasion once at Bandyup. In addition, Baby Z's mother admitted in her police statement that she had fallen asleep while feeding Baby Z in her bed at Bandyup a couple of times in the time leading up to the day of his death.[252]

159. Having considered all the evidence before me, I am satisfied that Baby Z's mother did engage in co-sleeping with Baby Z on occasion, but there is insufficient evidence to allow me to make a finding that Baby Z was co-sleeping with his mother at the time that he died.

160. Given the cause of death has not been established and the known circumstances raise the possibility of both natural and accidental causes, I am unable to reach a conclusion as to the manner of death. Accordingly, I make an open finding as to the manner of death.

[248] T 19 – 20; Exhibit 1, Tab 19 [7] – [11].
[249] Exhibit 1, Tab 19 [13].
[250] T 25.
[251] Exhibit 1, Tab 19 [14] – [16].
[252] Exhibit 1, Tab 8 [37] – [39].

QUALITY OF SUPERVISION, TREATMENT AND CARE

161. Under s 25(3) of the *Coroners Act*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care. Given this case has been treated by the State Coroner as a death in care, I have undertaken the same exercise.

Medical Care while at KEMH

162. Dr Andrew Kennedy, who is currently the Senior Staff Specialist Paediatrician and Adolescent Physician at Westmead Hospital in Sydney and was previously based at Princess Margaret Hospital, was asked by court to provide his opinion on the medical care provided to Baby Z in hospital as well as the level of care provided to him in Bandyup. Dr Kennedy provided two written reports and also gave evidence at the inquest.[253] In relation to his care at KEMH, Dr Kennedy's evidence was that it was very clear that Baby Z was given "absolutely appropriate and very good medical and nursing care."[254]

163. The evidence supports the conclusion that the medical treatment and general care provided to Baby Z at KEMH was of a high standard and, after a short period after birth when he required respiratory support, he was generally a 'well' baby who was starting to thrive. The concerns that arise in this case relate more to issues of supervision, in the sense of the decision to discharge him into his mother's care at Bandyup and also the various processes available to supervise his care once at Bandyup.

Decision to discharge Baby Z and his mother to Bandyup

164. Ms Celine Harrison was the Head of Social Work at KEMH at the time Baby Z was born. She is a qualified psychologist and social worker with a very long history of involvement in social work at KEMH, as well as at Princess Margaret Hospital and DCP in the past. Ms Harrison explained that at KEMH there are various layers of communication between social workers and medical and nursing staff, so that medical and social issues can be integrated with the main aim of ensuring that each child is safely discharged from the hospital.[255]

165. There were some obvious lapses in the flow of information in this case, in relation to Baby Z's mother's concerning entries over the weekend prior to her discharge, as well as the communication surrounding the decision to discharge on the Monday morning. The communication lapses seem to have arisen both within KEMH and between KEMH, DCP and the relevant Bandyup staff.

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[253] T 87 – 110; Exhibit 1, Tabs 50 and 51.
[254] T 91.
[255] T 184 – 185.

166. Ms Harrison described the events surrounding Baby Z and his mother's discharge as a "perfect storm", because there were a number of things that happened that do not normally happen. Ms Harrison indicated that it was very unusual to have the mother readmitted as a post-natal patient to hospital and for her baby to move from the neonatal clinical care unit to the general ward. Ms Harrison also considered it unusual that, with such a complex case, the different teams within the hospital did not get together with Bandyup and DCP staff to discuss the matter before discharge.[256] Ms Harrison surmised that if they had done so they would have "found that what they had was a woman who was exhausted and needed support."[257]

167. Ms Harrison has clearly given a lot of attention to what occurred in this case. She described doing a "line by line analysis" of the medical records and noted there were "about 30 entries that described mother-infant interaction between the 17th and the 21st."[258] Ms Harrison went so far as to prepare a timeline of what occurred, which she helpfully provided to the court during the inquest.[259]

168. Ms Harrison noted that there were as many or more interactions that were neutral or described as normal, as there were others that could be described as concerning in relation to her drowsiness and mood.[260] So on the Monday morning, Ms Harrison thought there was "a considerable degree of ambiguity about the mother-child attachment" but "the overlying feature was drowsiness and exhaustion."[261] Ms Harrison agreed with Dr Hamilton's suggestion when giving evidence that, in hindsight it would have been preferable to keep Baby Z's mother in hospital for another day for observation.[262]

169. In her evidence Ms Harrison explained that an option that was available to Ms Staines on the Monday was to escalate the matter to her, in which case Ms Harrison would have gone through the notes and documented that discharge at that point was not safe from a social work point of view, which would have stopped the discharge at that time until further discussions could be had with Bandyup and DCP.[263]

170. However, Ms Staines was very new to the position at the time and it seems she was presented with a situation where everyone, including Baby Z's mother, was proceeding on the assumption, and the expectation, that the discharge back to Bandyup would occur and Ms Staines was too inexperienced to know how to manage the situation. Ms Harrison acknowledged that "it takes considerable

[256] T 185 – 186.
[257] T 187.
[258] T 186.
[259] Exhibit 9.
[260] T 186 – 187.
[261] T 187.
[262] T 187.
[263] T 189, 191.

fortitude against all of those forces to take a stand on it."[264] There would also have been the reassurance that DCP and Bandyup staff would continue to be involved in monitoring Baby Z's care.[265] In those circumstances, Ms Harrison did not think that Ms Staines' decision was unreasonable.[266]

171. Ms Harrison did, however, consider that the concerns documented in the medical notes on 18, 19 and 20 March 2011 should have been passed on to DCP as well as notification of the discharge before it occurred.[267] Ms Harrison attributed the failure to notify DCP of the discharge as perhaps because Baby Z's mother was going to Bandyup rather than into the community.[268] Ms Harrison also accepted that DCP had been given at least some indication that discharge might occur on the Monday via an email from Ms Staines to DCP on 17 March 2011, where Ms Staines wrote,"[i]t is thought that [Baby Z's mother] will remain in hospital until Monday, until her pain is under control."[269] I accept that this would at least have given DCP some notice that discharge was being considered for the Monday, but it does not alter the fact that the ultimate discharge decision was not communicated to DCP until a DCP staff member called KEMH that afternoon, hours after the event.

172. Ms Harrison has since retired and at the inquest evidence was given by the next Head of Social Work at KEMH, Ms Jenny O'Callaghan, who is now the Director of Women's Health Clinical Care Unit at KEMH.[270] Ms O'Callaghan acknowledged in a report provided to the court that the information shared with DCP by Ms Staines did not highlight the extent of the documentation in the medical notes regarding issues for Baby Z's safety and his mother's capacity to care for him.[271] Ms O'Callaghan explained at the inquest that she would have expected, in those circumstances, for some kind of summary of the notes and issues of concern to have been communicated to DCP at an early stage after discharge to inform the next Signs of Safety meeting[272] (which one can speculate might have been brought forward in those circumstances).

173. Ms O'Callaghan also agreed with Ms Harrison that it would have been reasonable in the circumstances for Ms Staines to have approached Ms Harrison and arranged for the discharge process to be slowed down to allow better communication with DCP about the events over the weekend.[273] However, Ms O'Callaghan also noted that there would have been some pressure to persist with the Monday morning discharge

[264] T 190.
[265] T 191 – 192.
[266] Exhibit 9.
[267] T 193 – 194.
[268] T 194.
[269] T 196.
[270] T 198; Exhibit 2, Tab 3.
[271] Exhibit 2, Tab 3.
[272] T 199.
[273] T 200 – 201.

plan, given both mother and baby were medically well and there is always pressure for hospital beds.[274]

174. Ms Barnett, the Executive Director of DCP, agreed that she would have expected that KEMH social work would have made some contact with DCP before discharge that day.[275] Ms Barnett indicated at the inquest that "the expectation is that there would be a very free flow of information"[276] between KEMH and DCP and "any relevant information about the safety of a child, born or unborn, will be shared to make the best arrangements possible for the interests of that baby."[277]

175. Ms Harrison accepted that if DCP had been advised of the ambiguity in the medical notes over the weekend about Baby Z's mother's mothercrafting skills and drowsiness, it may have added a layer of concern.[278] Ms Barnett agreed that DCP staff would have wanted to know that information and understand it a bit more, ideally by having a planning meeting for discharge with DCP, KEMH and Bandyup staff.[279] However, Ms Barnett also indicated that none of the information she had since received suggested that there were any concerns that would have prompted urgent statutory intervention by DCP.[280] In those circumstances, the transfer of mother and child to Bandyup would most likely have still proceeded once they were medically cleared for discharge.[281]

176. The medical evidence also supports the conclusion that the decision to discharge would have occurred around the same time or perhaps delayed for another day at most, even if all the information had been communicated between KEMH staff.

177. I asked Dr Kohan, a very experience neonatologist, whether the notes of events over the weekend prior to Baby Z's discharge caused him any concern, and he indicated that he thought the improvement recorded over that length of time was satisfactory and a sufficient period to provide some reassurance that Baby Z's mother was capable of caring for him appropriately. He emphasised that Baby Z was a 'well baby' at that time, so really it was only the maternal situation that required observation. That was a matter for the KEMH social workers and DCP.[282]

178. Although Dr Kohan was not involved in the final decision to discharge Baby Z, he had reviewed the notes and maintained that the decision to discharge him was appropriate and keeping him in for another couple of days would have made no difference in this case.[283] He acknowledged

[274] T 200 – 203.
[275] T 257.
[276] T 253.
[277] T 253.
[278] T 195.
[279] T 259.
[280] T 258.
[281] T 259.
[282] T 44 – 46, 60.
[283] T 53.

that he had no personal experience of prisons and stated, "I really don't know how safe it is to send babies to Bandyup."[284] However, Dr Kohan also pointed out that babies sent home to a normal household have only sporadic health check-ups and if a nurse and child health nurse were able to review Baby Z sporadically, that was all he needed.[285]

179. Dr Hamilton described Baby Z's mother as "a difficult and complex patient from both the medical and psycho/social point of view." Her pain management issues had led to a high analgesia requirement, which caused some drowsiness, and her frustration and agitation at the hospital situation was treated with diazepam, which caused further drowsiness. On discharge she was given no diazepam and, according to Dr Hamilton, the analgesia medications were non-sedating.[286] As far as Dr Hamilton was aware, it was Baby Z's mother's observed drowsiness and her sometimes agitated behaviour that had caused some concern about her ability to care for Baby Z independently.[287] However, Dr Hamilton believed she was considered to show appropriate concern for the wellbeing of Baby Z and was well bonded with him.[288]

180. As noted above, Dr Hamilton had hoped to review Baby Z's mother again before her discharge but did not get that opportunity as the discharge occurred before she arrived on the ward on the Monday morning. Dr Hamilton was asked, in hindsight, whether she might have done anything differently if she had seen Baby Z's mother and reviewed her charts on that Monday morning. Dr Hamilton suggested that she might have kept Baby Z's mother in hospital for one more day but she conceded that she didn't know if it would have made any difference.[289] The main difficulty was that she wanted to see how Baby Z's mother appeared once she was weaned off diazepam, but due to the effect of the hospital environment on Baby Z's mother it was difficult to achieve that reduction in the diazepam dose until she left KEMH.[290]

181. In relation to the decision to discharge Baby Z and his mother back to Bandyup, Dr Kennedy expressed a similar view to other experts such as Dr Hamilton, in that "it might have been nice to perhaps wait another day or so,"[291] but only in relation to simply seeking some reassurance that Baby Z's mother's drowsiness had resolved and her mothercrafting was satisfactory.[292]

182. What became clear after hearing all of the evidence was that what occurred in this case was unusual and many witnesses expressed some surprise and concern at the communication lapses.[293] However, the witnesses also agreed that later events would suggest that even if

[284] T 41, 53.
[285] T 42, 60 – 61.
[286] Exhibit 1, Tab 32, p. 6.
[287] Exhibit 1, Tab 32, p. 6.
[288] Exhibit 1, Tab 32, p. 6 - 7.
[289] T 137.
[290] T 137.
[291] T 94.
[292] T 94, 107.
[293] T 186, 259.

proper procedures had been followed and there had been a free flow of communication between DCP and KEMH staff, the only likely change would have been that the discharge was delayed slightly. In the end, Baby Z would still have gone to Bandyup with his mother, as per the original plan, on or about 21 March 2011.[294]

183. Ms Harrison advised that following Baby Z's death a review of his care prompted an amendment to the KEMH Social Work Policy Manual in relation to women being discharged to prison with babies. The protocol now requires that where a baby is to be discharged to Bandyup or Boronia the KEMH social worker is to hold a discharge planning meeting with the relevant prison staff including the Ngala worker, DCP, the midwifery manager for the ward and the mother herself, if possible.[295]

184. Ms O'Callaghan also informed the court that another change to practice that she has initiated is the inclusion of social work notes within the medical file, rather than the former practice of holding social work notes separately. Ms O'Callaghan explained that this change avoided the risk of communication not being clear between the departments.[296]

185. In addition, Ms O'Callaghan has brought into practice a requirement that all social workers at KEMH need to undertake the safe-sleeping e-learning module when they commence employment. Ms O'Callaghan has also arranged for some staff training by members of the SIDS Foundation about the risks of co-sleeping. Ms O'Callaghan has the expectation that the social work staff will note any issues of co-sleeping in the mother's medical notes and address that as a concern around keeping the baby safe with the mother. If the problem persists they will raise it as a concern with DCP.[297]

186. A statement from the current Head of Social Work at KEMH, Vicki Ann Butcher, was also tendered as an exhibit at the inquest.[298] Ms Butcher indicated that the changes implemented by Ms O'Callaghan remain in practice. In addition, a new guideline known as SW5 Obstetrics Patients Protocol (Obstetrics Protocol) was introduced in August 2014. The Obstetrics Protocol which sets out the procedure for holding a discharge planning meeting with relevant staff for a patient who is in custody. The Obstetrics Protocol states the meeting should include the social worker, the Ngala worker, the Family Links Officer, the midwifery manager for the ward and the mother herself.[299] Ms Butcher expresses the opinion in her statement that if a discharge planning meeting had been held in this case, "it could have resulted in a better outcome because it would have created the opportunity for an open discussion

[294] T 264.
[295] Exhibit 1, Tab 26, [6] and CH2 – Social Work Protocol 5.4.4, [1.11]
[296] T 199.
[297] T 203.
[298] Exhibit 7.
[299] Exhibit 7 [33] – [35].

to take place between the social work and the relevant prison staff about mothercrafting issues."[300]

187. There is also a guideline in relation to Handovers that requires social work staff to complete a handover form outlining any social concerns and fax the completed form to the external agency receiving the patient, such as when a prisoner returns with her baby to Bandyup.[301]

188. Ms Butcher also advises that she ensures that all social workers at KEMH receive regular supervision, the extent of which will depend upon their experience. Ms Butcher also supervises all cases where DCP are involved.

189. At the time Baby Z was discharged from KEMH there was a Memorandum of Understanding (MOU) in place between DCP and both KEMH and the Department of Corrective Services.[302] The MOU with KEMH appears to have anticipated that the decision about whether statutory action would be taken by DCP would be decided *prior to* the birth. As such, the MOU seems to have primarily covered pre-birth procedures.

190. Mr Boardley at KEMH wrote to Ms Barnett on 12 January 2010 indicating the need to incorporate post-birth procedures into one document to cover those processes that need to occur if child protection risks emerge as an issue after the birth of a baby.[303] It appears, from the updated MOU provided in the brief of evidence that this has now been done as the MOU addresses both unborn and newborn babies.[304]

191. I am satisfied that the new procedures implemented since the death of Baby Z have improved communication between the relevant agencies, although I also accept that the communication lapses in this case did not contribute to Baby Z's death.

192. In addition, Mr Boardley, as the current Executive Director of Midwifery, Nursing and Patient Support Services at KEMH, has suggested that two improvements could be added to KEMH's processes to ensure that a similar situation to what happened with Baby Z and his mother's discharge did not occur again. These suggestions relate to changes to implementing more regular documented mothercrafting assessments by midwives during shifts and the implementation of a postnatal discharge for patients readmitted shortly after birth and discharge (as occurred with Baby Z's mother).[305] The suggested new procedures are indicative of the fact that KEMH is still constantly seeking ways to improve their processes, which can only be a positive thing.

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[300] Exhibit 7 [36].
[301] SW2 Clinical Handover; Exhibit 7 [37] – [38].
[302] Exhibit 2, Tabs 1.5 and 1.6. The MOU in place with KEMH was reviewed and updated in July 2013 – Tab 1.7.
[303] Exhibit 2, Tab 1.5.
[304] Exhibit 2, Tab 1.7.
[305] Exhibit 10[47].

Muster Checks and Cell Checks for resident children

193. At the time of Baby Z's death none of the musters or routine checks by prison officers recorded residential children and the Bandyup Nursery Coordinator indicated that on any particular day staff would have difficulty confirming the number of children residing in the prison. It seems this was justified on the philosophical basis that welfare checks of children were not to be performed by custodial staff as this responsibility rested with the child's mother. The child was simply a visitor to the prison.[306]

194. The evidence in relation to the cell checks at night is that the prison officers go to the outside of the Nursery building and approach each prisoner's cell. They turn on a light and look through a viewing hatch into each prisoner's cell. The view of the interior of the cell is provided via a convex mirror.

195. At the time of Baby Z's death the prison officer's duty was to sight the prisoner inside each cell and enter the number of prisoners in the occurrence book. They were not required to sight the baby, although they were instructed to check that there was no baby asleep in the bed with the mother, due to the dangers associated with co-sleeping. If a baby was in bed with their mother, the prison officer would bang on the window and wake them up and instruct the mother to put the baby in the cot.[307] If the baby was not in the bed, then it would not be uncommon for the prison officer not to view the baby. The prison officer would not necessarily even be aware if there was a baby in the cell, as that information was not readily available and pregnant women are also housed in the Nursery unit.[308]

196. At the conclusion of the Directed Review following Baby Z's death a recommendation was made that Bandyup develop a system to account for residential children and children on overnight stays.[309]

197. Since that time a change in policy has been implemented in relation to monitoring of children in prison during musters and cell checks.[310] It is noted in the order that it is a head count, not a welfare check.[311] There is now a laminated card at the viewing hatch of each cell which indicates whether the prisoner has a child living with them or not. In addition, on the muster board next to the mother's name there is a label that states she has a baby with her in prison. They are also listed as a registered visitor on TOMS. Therefore, prison officers are now aware if a baby is meant to be in the cell and will include the baby in

[306] Exhibit 4, Tab 1, Directed Review, p. 11 – 12.
[307] T 20.
[308] T 22.
[309] Exhibit 4, Tab 1, Directed Review, p. 12, 17.
[310] Exhibit 2, Tab 2.2 – Local Order 24, Part 4 – Counts of Residential Children on Site.
[311] Exhibit 2, Tab 2.2 – Local Order 24, Part 4 – Counts of Residential Children on Site.

their headcount. If during a night time cell check the baby can't be seen, the prison officer will wake the mother and ask her to show them the baby (even though this practice often provokes a negative response from the mother due to being woken).[312]

Co-sleeping

198. Co-sleeping has always been prohibited in the Nursery unit and mothers have been evicted from the unit for repeatedly contravening that prohibition.[313]

199. The minutes of the Bandyup Paediatric Meeting that took place the week before Baby Z's mother was discharged with Baby Z back to Bandyup indicate that co-sleeping was a topic of concern for the staff involved with the Nursery prisoners. A Senior Officer raised what should be done if prisoners were caught repeatedly sleeping with their babies. Ms Akers indicated that she had put up posters regarding SIDS and was in the process of arranging to have the SIDS team come out to talk to the women. She also advised that specific prisoners were told that if they did it again their circumstances would come under serious review. It was noted that the events should be put on an Incident Report rather than Offender Notes so that senior staff could be aware of them.[314] The minutes show that the staff at Bandyup were alert to the likelihood of co-sleeping occurring with prisoners in the Nursery unit, despite the policy against the practice, and were pro-active in educating prisoners in relation to the dangers of co-sleeping.

200. I am satisfied that Baby Z's mother had been repeatedly counselled against co-sleeping with Baby Z, and had been educated more than once about safe sleeping practices both at KEMH and in Bandyup, which is an indicator that the education was being properly provided to prisoners at Bandyup. Ultimately, it requires the mothers to then be proactive in following that advice.

201. As to whether it was a common problem prior to Baby Z's death, the evidence of the prison officers generally suggested that it occurred, but not regularly. Similarly, during the inquest Ms Margaret Owens, who was the Manager for Children and Community Programs at Ngala, indicated that in her experience co-sleeping was not an issue that regularly came up in Bandyup, although it was an issue addressed on occasion.[315]

202. The new night-time cell check system, which actively requires the baby to be sighted, will hopefully result in the instances of co-sleeping in the Nursery unit occurring even less often.

[312] T 22, 30 – 31, 270 – 271.
[313] T 29 – 30, 33; Exhibit 3, Tab 15.
[314] Exhibit 4, Tab 24.s
[315] T 282 – 283.

203. I make no further comment on this issue, given the evidence was insufficient to find any more than that co-sleeping could not be excluded as a possible contributor to Baby Z's death.

Cell Call System

204. Unit 5 has one telephone for the emergency call system, which is situated in the living room. It is part of a stand-alone telephone system and connects to the Entry Control Officer at the prison. When the telephone handset is lifted it makes a direct connection with Entry Control. It is a safety mechanism intended for use in emergencies.[316]

205. The telephone records show multiple (40) call failures were created from Unit 5 during the incident. The call summary confirms three successful calls were answered by Entry Control at 3.36 am, 3.37 am and 3.59 am. There is a six minute discrepancy between the time the first call is recorded on the system at 3.36 am and the time of 3.30 am the Entry Control Officer recorded he took the call in an incident report. The discrepancy seems to be explained by the possibility that the internal clock for the phone system was inaccurate.[317]

206. As to the evidence of prisoners that calls failed or were not answered, Sergeant Donkin explained that his enquiries indicated the first call was answered by an officer at Entry Control and then another call was answered a minute later but repeated subsequent calls failed as a person using the phone repeatedly pressed the 'hang-up' button. That is consistent with the witness statement of Ms Chadwick, who made repeated calls in a panicked state.[318] Officer Muller heard the calls, which recalls were on an open line for an extended period of time, and she gave evidence that she couldn't understand a word of what was being said but she got goosebumps nonetheless as it was apparent something terrible had happened.[319] Mr Henderson, who had listened to recordings of the calls before giving evidence, also described the calls, as 'quite spooky, because you know stuff's happening and things are happening but you don't know what."[320]

207. The evidence before me does not suggest that the cell call system was not working properly that evening. Rather, due to the extreme distress and understandable panic of the prisoners in the unit, they were not able to work the system properly.[321]

208. Despite the difficulty understanding what had occurred, the prison officers understood that a serious incident had occurred at the unit and I'm satisfied that they attended as quickly as they could. Officer Muller, who I considered to be a reliable witness, estimated it took her four minutes from the first call to get to the unit. She described the scene when she arrived at the Nursery unit as "utter hysteria" with "four

[316] T 8, 275; Exhibit 4, Tab 1, Directed Review, pp. 5, 11.
[317] T 8 – 11.
[318] T 12.
[319] T 27.
[320] T 276.
[321] T 27.

screaming, hysterical parents, all with babies in their arms."[322] I have no doubt that in those circumstances every second that passed would have felt much longer to each of the prisoners in the unit who were desperately waiting for help to arrive, and the delay in total to seem like as long as half an hour, even though in fact it was only a matter of minutes.

Resident children at Bandyup

209. At the conclusion of the inquest I indicated that I was unlikely to explore the issue of the desirability of babies residing with their mothers in prison to any great extent. That is predominantly because the weight of the evidence before me was wholly supportive of the practice continuing.

210. Although it might, at first glance, appear a potentially dangerous and uncontrolled environment in which to house a baby, in fact the opposite appears to be true. Many of the witnesses spoke of the prison environment being a positive feature in that it provided a safer environment for the mother and baby than might exist for them in the general community, when considering the vulnerability and troubled history of many of these women.

211. Ms Harrison noted that KEMH social workers dealt with 500 very complex women in 2011 and the twenty or so mothers from Bandyup were "by no means the most complex, because there's someone looking after them, and they've got a roof over their heads."[323]. Ms Barnett agreed that in some cases DCP staff consider prison to be a safer environment for the mother and baby than being in the community.[324] She explained that this was because there are "more eyes on mother and baby in a place like Bandyup than what there would be if mum is out in the community on her own with the baby."[325]

212. Ms Barnett described it as "a window of opportunity"[326] for the mothers in Bandyup, where they can make some positive changes in their lives. It is an environment where they are (hopefully) drug-free, they have accommodation and they have time to spend with their babies without potential unhealthy external influences.

213. That indeed seems to have been the case for Baby Z's mother, as the evidence from DCP was that their primary concern was not for Baby Z's care while he was with his mother in prison, but rather where they would go upon release from prison. No concerns were raised with DCP about Baby Z's mother's care of Baby Z once they were at Bandyup, and all the evidence suggested she loved her baby and was doing her best to provide him with good care.[327]

[322] T 27.
[323] T 191.
[324] T 263.
[325] T 260.
[326] T 263.
[327] T 251.

214. Mr Henderson, who in his role as Assistant Superintendent of Operations and Deputy Superintendent at Bandyup has a significant role to play in how mothers and babies are managed at Bandyup, was asked how he felt the processes of having babies with prisoners worked, in general. He responded, "I think it works very well."[328] Mr Henderson explained that at any given time there are 9 or 10 women who are pregnant on site with an average of 10 births a year to prisoners. He agreed with Ms Harrison and Ms Barnett that many of the women may not have had the opportunity to bond with the child in a safe environment if they were not in prison.[329] In his opinion "the benefits far outweigh the risks"[330] and he supports the practice continuing.

215. In terms of the risk of harm to a baby in prison, the fact that Mr Henderson was able to advise that the death of Baby Z was the first death of a baby at Bandyup in the 25 years since the procedure of resident children began, is reassuring.[331] Nevertheless, despite its rarity, I note that there were procedures in place to deal with the death of a baby in prison, and those procedures appear to have been followed in this instance.[332]

216. The only witness who raised any significant concern in relation to the practice of having babies at Bandyup was Dr Kennedy, and his concern was specifically in relation to the provision of health care to the babies within the prison. This was based upon Dr Kennedy's understanding that the prison health staff do not have a responsibility to provide health care to the babies.

217. Dr Kennedy expressly stated that did not consider the practice of having babies in prison either undesirable or inherently unsafe. However, he noted that young babies can become sick very, very quickly because they don't have a lot of reserve, and in those circumstances he would be concerned if the prison health team absolved themselves of any responsibility to care for the baby.[333] Dr Kennedy accepted that for a generally well baby, such as Baby Z, only routine health check-ups would have been necessary, but it was in the event of an emergency that he was most concerned that there should be no delay in treatment being provided.[334]

218. Dr Kennedy was enthusiastic when told about the reported changes to KEMH procedure to include a discharge planning meeting with all relevant Bandyup staff, so that there is some continuity of care and knowledge about the baby's needs before going to prison.[335]

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[328] T 276.
[329] T 276.
[330] T 276.
[331] T 276 – 277.
[332] Exhibit 4, Tab 7.
[333] T 90.
[334] T 90, 100.
[335] T 107 – 108.

219. Dr Kennedy also acknowledged during the inquest being pleased and surprised to see that on one occasion the health staff at Bandyup had attended to Baby Z's health needs when he had some conjunctivitis, which reassured him that on a given shift a nurse could use good judgment to still treat a baby's needs if required.[336] However, he remained concerned about the absence of a clear role of health staff in the baby's day to day health care.[337]

220. I am informed that after Baby Z's death the Department sought further clarification as to the scope of the health staff's duty of care to the babies at Bandyup and Boronia. The advice suggests that prison health staff have a general duty to ensure that the children are provided with a reasonable standard of care in the event that they become unwell. The Department's Health Services Policy Manual reflects that position and outlines that health services staff are required to take responsibility for ensuring that medical attention is delivered to resident children.[338] This policy would appear to satisfy the concerns raised by Dr Kennedy.

221. There is nothing in the evidence before me to suggest that the prison staff did not fulfil that duty in their care of Baby Z on the night he died.

222. As to the general health care provided to resident children in prison, I am satisfied that the services provided are sufficient to ensure that their health needs are well met.

CONCLUSION

223. On 3 April 2011 Baby Z died suddenly while residing with his mother at Bandyup Women's Prison. The subsequent investigation into his death has been unable to ascertain a cause of death. Baby Z's death is another sudden unexpected death of an infant child where medical experts are unable to explain why it occurred. All that can be ascertained from the available evidence is that it is possible he died from either a natural or accidental cause, or a combination of both.

224. As well as trying to ascertain why and how Baby Z died, the inquest into Baby Z's death also explored issues in relation to how pregnant women and mothers of newborns are managed in the Western Australian prison system. The evidence before me indicates that overall the systems are well-designed and implemented, although there is always room for improvement.

225. A number of government agencies were involved in Baby Z's short life, including staff at KEMH, staff at DCP and staff at Bandyup. They all acted to the best of their abilities to ensure that he remained safe and well while maintaining a bond with his mother. It seems that their endeavours were successful, in that Baby Z's mother was able to form a

[336] T 104 – 105.
[337] T 108 – 109.
[338] Exhibit 4, Tab 32.

loving and close attachment to him in the few weeks they were together and appeared to be caring for him well. Baby Z's mother described Baby Z as her hope for the future, and she was grief-stricken at his death. Her loss is no doubt compounded by the fact that she is unable to have any more children.

226. In conclusion, I have found that, despite some communication failures, the overall management of Baby Z's treatment, care and supervision in his few weeks of life was of a high standard and his tragic death cannot be attributed to any the agencies involved in his care.

S H Linton
Coroner
27 September 2016