Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 65/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of a male child referred to as ***Child SH*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***1 November 2019*** *find that death occurred on* ***1 September 2018*** *at* ***Perth Children's Hospital*** *from* ***aspiration pneumonia, with terminal palliative care, in a male child with complex medical co-morbidities including congenital myopathy and arthrogryposis*** *in the following circumstances:-*

Counsel Appearing:

Sergeant L Housiaux assisted the Coroner

Ms J Theunissen (State Solicitor's Office) appeared on behalf of the Department of Communities; the Child and Adolescent Health Service.

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SUPRESSION ORDER

Suppression from publication of the deceased's name and any evidence likely to lead to the deceased's identification. The deceased is to be referred to as 'Child SH'.

Order made by: BP King, Acting State Coroner (24.07.19)

INTRODUCTION

1. Child SH (the deceased) died at Perth Children's Hospital (PCH) on 1 September 2018 from aspiration pneumonia. He was 5-years of age. At the time of his death, he was in the care of the Director General (DG) of the Department of Communities (the Department).[1],[2]

2. Accordingly, immediately before his death, the deceased was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was therefore a "*reportable death*".[3] In such circumstances, a coronial inquest is mandatory.[4]

3. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[5]

4. The documentary evidence at the inquest included independent reports prepared by the WA Police[6] and the Department.[7] The Brief comprised one volume.

5. Dr Murray Princehorn, (Consultant General Paediatrician) and Mr Andrew Geddes, (the Department's Executive Director, South Metropolitan Community Service Delivery) gave oral evidence at the inquest. The inquest focused on the management of the deceased's medical conditions and the involvement of the Department in his life.

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[1] Exhibit 1, Tab 15, Letter - Ms Z Mair, Department of Communities (undated)
[2] Exhibit 1, Tab 17, Interim Order - Children's Court of Western Australia (09.08.18)
[3] Section 3, *Coroners Act 1996* (WA)
[4] Section 22(1)(a), *Coroners Act 1996* (WA)
[5] Section 25(3) *Coroners Act 1996* (WA)
[6] Exhibit 1, Tab 2, Report - Coronial Investigation Squad
[7] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19) & Tab 9D, Report - Ms N Leggett (30.10.19)

THE DECEASED

Background

6. The deceased was born prematurely on 25 August 2013, at King Edward Memorial Hospital[8] and he died on 1 September 2018, from aspiration pneumonia at PCH.[9] In view of his significant medical issues, it was thought that the deceased would be unlikely to live more than one or two years.[10]

7. The deceased reportedly had seven siblings and was largely cared for by his mother, who described him as "*a strong spirited boy*", whom she loved dearly.[11] The deceased was said to have adored his younger sister, who adored him in return. During their last visit together at PCH on 31 August 2018, she constantly hugged and kissed him, and he indicated his pleasure at her doing so.[12]

8. From time to time, significant concerns were raised for the deceased's safety, and this led to the Department's involvement with his family on 23 occasions, predominantly with respect to allegations of neglect or exposure to family and domestic violence.[13] An overview of the Department's involvement with the deceased is set out later in this Finding.

9. The deceased's long-term consultant paediatrician, Dr Princehorn, made the following observation:

> [The deceased] was a delightful little boy who was always expected to have quite a short life due to his severe disability and indeed lived much longer than his neurologist expected. Despite the sadness of his death, all the staff at Perth Children's Hospital who were involved with [the deceased] I am sure feel quite privileged to have known him and been able to care for him, particularly during his last illness.[14]

10. It is clear that during his short life, the deceased had a profound impact on the health professionals involved in his care.[15,16]

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[8] Exhibit 1, Tab 16, Deceased's birth certificate
[9] Exhibit 1, Tab 1, Report of Death (P100)
[10] ts 01.11.19 (Princehorn), pp10-11
[11] Exhibit 1, Tab 6, File note - Discussion with the deceased's mother (13.09.18), p2
[12] Exhibit 1, Tab 2, Report - Coronial Investigation Squad, p6 & Tab 18, Deceased's Inpatient notes (31.08.18)
[13] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p3
[14] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), p2
[15] Exhibit 1, Tab 18, Deceased's Inpatient notes
[16] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), p2

Overview of medical conditions

11. The deceased was born with the following serious congenital conditions:[17,18,19]

i. *Undifferentiated congenital myopathy*: a disorder of the muscles, that causes weakness and loss of muscle tone. In the deceased's case, this condition caused him to have difficulties with breathing and feeding. Dr Princehorn noted that tests had shown that the deceased had no ability to regenerate muscle cells and that when these cells died, they were replaced with fibrous, fatty tissue.

ii. *Arthrogryposis*: this term relates to the fact that the deceased had congenital joint contractures, meaning that his limbs did not work correctly. Whilst the deceased was in his mother's womb, he was unable to move normally because of his myopathy. This resulted in him being in an unusual muscloskeletal position and led to his elbows and wrists developing a fixed flexion deformity.

iii. *Severe kyphoscoliosis*: this term describes the abnormal curvature of the deceased's spine which also caused his internal anatomy to be altered.

12. The deceased's medical history also included:[20]

- Recurrent aspiration pneumonia;
- Recurrent upper and lower respiratory tract infections;
- Laryngomalacia (floppy larynx);
- Obstructive sleep apnoea (when he was younger);
- Micrognathia (undersized jaw) and a high arched palate;
- Oligodactyly (less than 5 fingers);
- Talipes (club foot) and an inguinal hernia;
- Developmental dysplasia of the hips; and
- Refractive accommodative esotropia (squint).

[17] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), p1
[18] Exhibit 1, Tab 14, Departmental submission to withhold medical intervention (24.08.18), p2
[19] ts 05.11.19 (Princehorn), pp7-8
[20] Deceased's Medical records (H7476223)

13. Although Ms Tang's report states that the deceased was born with a "*severe intellectual disability*",[21] Dr Princehorn said it was difficult to tell if this was the case. The deceased's physical limitations made it impossible for him to undergo standard tests used to determine cognitive ability. Dr Princehorn expressed the following view on this issue:

> I suspect he wasn't cognitively impaired; I can't be sure of that, but Child SH could express himself with his eyes and there was some relative preservation of ocular movement and to some extent, perhaps, some of the muscles of his face – the upper muscles of his face. He could move his head and neck, a little, to express pleasure or sometimes displeasure.[22]

14. In any event, the deceased was unable to walk and he used a wheelchair. He was also non-verbal, although he could make vocalisations. Dr Princehorn described the deceased as: "*a very complex, high needs child*" who was: "*reliant on a carer for all his activities of daily living*".[23]

15. Because of his myopathy, the deceased had an "*unsafe swallow*" and was unable to consume food in the usual way. He underwent a procedure known as a percutaneous endoscopic gastrostomy (PEG) and was fed by means of a tube that was permanently inserted into his stomach. By the time of his death, the PEG tube had been replaced because the deceased was no longer tolerating it. Instead, he underwent a percutaneous endoscopic jejunostomy (PEJ) procedure where a feeding tube was inserted into his jejunum (the middle section of the small intestine, where most nutrients in food are absorbed).[24]

16. The deceased's issues with swallowing resulted from his congenital myopathy and led to numerous admissions for aspiration pneumonia and respiratory tract infections.[25] As Dr Princehorn explained, the deceased was unable to effectively clear saliva which made him prone to infections. Although he was on medication to reduce his saliva production, the dose had to be carefully calibrated because a potential side effect of too much of the medication, was to make his airway secretions too thick.[26]

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[21] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p4
[22] ts 05.11.19 (Princehorn), p8
[23] ts 05.11.19 (Princehorn), pp8, 9, 12 & 16
[24] ts 05.11.19 (Princehorn), pp9-10
[25] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), pp1-2
[26] ts 01.11.19 (Princehorn), p9

17. In the 12 months prior to his death, the deceased was admitted to PCH on seven occasions and spent 137 days as an inpatient. His admissions during that period were as follows:

i. 02 - 14 Sep 2017: upper respiratory tract infection;

ii. 31 Jan - 13 Feb 2018: fever/weight loss;

iii. 21 - 29 Mar 2018: lower respiratory tract infection;

iv. 30 Apr - 05 Jun 2018: lower respiratory tract infection;

v. 20 Jun - 11 Jul 2018: lower respiratory tract infection;

vi. 18 - 25 Jul 2018: lower respiratory tract infection; and

vii. 30 Jul - 01 Sep 2018: aspiration pneumonia.[27]

18. During his admissions to hospital for pneumonia or respiratory tract infections, the deceased required non-invasive ventilation support. This was provided either by continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP). Nasal prongs or a mask are used to deliver oxygen to the patient in order to provide "*flow*", and thereby assist breathing by keeping the small airways (alveoli) open for longer.[28]

19. With CPAP, the flow is continuous, whereas with BiPAP, the flow is initiated when the patient draws breath. Dr Princehorn noted that not everyone is able to use BiPAP and it requires training and some getting used to. He said that BiPAP is often thought to be more pleasant for the user, but that he suspected there probably wasn't a great deal of difference between the two methods.[29]

The deceased's last admission

20. The deceased's admission to PCH on 30 July 2018 was related to aspiration pneumonia and indicated "*a progressive decline in his respiratory function due to his myopathy*." He required (CPAP) or (BiPAP) to assist with his breathing and he was treated with an intravenous antibiotic.[30]

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[27] PCH Discharge summaries attached to an email to the Court from State Solicitor's Office (01.11.19)
[28] ts 01.11.19 (Princehorn), p11
[29] ts 01.11.19 (Princehorn), p12
[30] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), pp1-2

21. During previous admissions, it had been possible to "*wean*" the deceased off respiratory support. However, during his last admission, the deceased's level of respiratory failure and his distress and anxiety from his shortness of breath (dyspnoea), meant that he was far more dependent on non-invasive ventilatory support (either CPAP or BiPAP). Low doses of morphine and midazolam were also used to manage the deceased's distress and anxiety related to his dyspnoea.[31]

22. On 14 August 2018, the deceased had a cardiac arrest and was resuscitated. On 18 August 2018, he was transferred back to the ward from the intensive care unit. He appeared to be in pain and discomfort and numerous attempts to contact his mother proved unsuccessful.[32]

23. For many years, the deceased's mother had consistently stated that she wished the deceased to be resuscitated in the event of an arrest. Following a meeting with the deceased's allied health team on 15 August 2018, it became apparent that her understanding of what resuscitation would mean for the deceased (with respect to issues such as invasive ventilation) was unclear.[33,34]

24. The deceased's treating team strongly believed that resuscitation was not in the deceased's best interests. In a letter to the Department dated 17 August 2018, Dr Princehorn and Dr Lisa Cuddeford set out the treating team's views in the following terms:

> [The deceased] should not experience invasive resuscitation techniques, such as intubation. This would cause a high level of physical and emotional distress with the outcome [neither] improving [the deceased's] quality of life nor increasing his life expectancy.[35]

25. On 20 August 2018, a child protection worker attended PCH and noted that the deceased appeared to be distressed when he was moved into different positions and that he cried on each occasion his ventilation mask was removed.[36]

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[31] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), p1
[32] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p4
[33] ts 01.11.19 (Princehorn), p19
[34] Exhibit 1, Tab 14, Departmental submission to withhold medical intervention (24.08.18), p3
[35] Exhibit 1, Tab 12, Letter - Dr L Cuddeford and Dr M Princehorn on behalf of the Clinical team (18.08.18)
[36] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p5

26. On 21 August 2018, a diagnostic contrast study found that fluid was leaking from the centre part of the deceased's PEJ tube which had also become malpositioned. Initial attempts to reposition the PEJ tube were unsuccessful and the deceased was fed intravenously until 29 August 2018, when his PEJ tube was successfully replaced under radiological guidance.[37]

27. On 23 August 2018, departmental staff attended a multidisciplinary team meeting at PCH. Dr Princehorn raised his concerns that the deceased was lonely and in need of emotional support. In response, the Department arranged for a volunteer mentor to sit with the deceased and read to him.[38]

28. Dr Princehorn and Dr Colin Derrick also briefed the meeting on the deceased's deteriorating medical condition and advised that CPR and/or intubation would be distressing and painful for the deceased, noting it would be a "*horrible way to die*".[39,40]

29. The deceased's mother's infrequent visits to PCH during his last admission were said to be often characterised by high levels of agitation and aggression towards staff. There were serious concerns for the deceased's mother's mental health and the impact that the deceased's death would have on her, especially since she had lost other children by way of death or by having them removed from her care.[41,42,43]

30. All of these factors made it difficult for hospital staff to have meaningful discussions with the deceased's mother about his resuscitation plan. Nevertheless, late in the afternoon of 23 August 2018, PCH staff spoke to the deceased's mother about the deceased's deteriorating medical condition. She agreed that invasive methods should not be used to resuscitate the deceased in the event of an arrest.[44,45] This agreement was recorded in a letter co-signed by Dr Derrick and Dr Andrew Wilson that same day.[46]

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[37] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), p1
[38] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p5
[39] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p5
[40] ts 01.11.19 (Princehorn), pp19-20
[41] Exhibit 1, Tab 14, Departmental submission to withhold medical intervention (24.08.18), p3
[42] ts 01.11.19 (Princehorn), pp18-19
[43] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), pp10-11
[44] Exhibit 1, Tab 14, Departmental submission to withhold medical intervention (24.08.18), p4
[45] ts 01.11.19 (Princehorn), pp19-20
[46] Exhibit 1, Tab 12, Letter - Dr C Derrick and Dr A Wilson (23.08.18)

31. The deceased's father, who was an inmate in a regional prison, was spoken to by departmental staff on 21 August 2018. He accepted the advice of the deceased's treating team and did not want invasive measures to be taken in an effort to prolong the deceased's life. He confirmed his position in writing on 22 August 2018.[47,48]

32. Although the deceased had been in the care of the DG since 2 August 2018, because of the gravity of the decision to cease medical intervention, staff at the Department and PCH had understandably decided to seek the views of the deceased's parents regarding the decision.[49,50]

33. On 27 August 2018, the DG approved the following recommendation by the deceased's field worker:

> That the Director General approves a plan, based on specialist medical and legal advice that, should [the deceased's] condition deteriorate further, a plan for 'Do Not Resuscitate' is agreed and that the medical team should provide the [the deceased] with appropriate palliative care and pain relief.[51]

34. The relevant approval for the 'Do Not Resuscitate' order, addressed to Medical Director at PCH, was signed on the DG's behalf on 28 August 2018.[52]

35. As it happened, the deceased became febrile and was treated with oral antibiotics on 28 August 2018. On 29 August 2018, his morphine and midazolam infusions were increased because of distress and anxiety related to his dyspnoea.[53,54]

36. During 30 August 2018, the deceased appeared to be distressed whilst wearing his nasal BiPAP mask, and a number of areas of skin breakdown on his face were noted. The mask was removed and a high-flow oxygen mask was placed near the deceased's head as a comfort measure.[55,56]

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[47] Exhibit 1, Tab 14, Departmental submission to withhold medical intervention (24.08.18), p3
[48] Exhibit 1, Tab 9, Report - Ms J Tang (01.03.19), p5
[49] Exhibit 1, Tab 14, Departmental submission to withhold medical intervention (24.08.18), p3
[50] ts 01.11.19 (Princehorn), p19
[51] Exhibit 1, Tab 14, Departmental submission to withhold medical intervention (24.08.18), p5
[52] Exhibit 1, Tab 12, Approval for a 'Do Not Resuscitate' order (28.08.18)
[53] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), p1 and ts 01.11.19 (Princehorn), p17
[54] Tab 18, Deceased's Inpatient notes (28-29.08.18)
[55] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), p2 and ts 01.11.19 (Princehorn), p17
[56] Tab 18, Deceased's Inpatient notes (30.08.18)

37. The deceased's antibiotics were ceased on 31 August 2018 and he described as looking "*so beautifully comfortable*" by nursing staff.[57] However, his condition continued to deteriorate and he died peacefully at about 5.15 am on 1 September 2018.[58,59,60]

Comment regarding resuscitation plan and treatment at PCH

38. In all of the circumstances, the deceased's 'Do Not Resuscitate' plan was clearly appropriate. His medical condition was deteriorating and invasive resuscitation techniques would have cause him pain and distress.[61]

39. The empathetic way in which both PCH and departmental staff interacted with the deceased's mother with respect to his end of life planning, which is apparent from the documents in the Brief, is to be commended.

40. The evidence establishes that the deceased received a high level of care at PCH during his numerous admissions and Dr Princehorn referred, in moving terms, to the care that staff provided the deceased.[62,63]

THE DEPARTMENT'S INVOLVEMENT WITH THE DECEASED

How the Department deals with safety concerns

41. At the relevant time, one of the ways that the Department responded to allegations of child neglect, abuse and/or safety concerns was by conducting a Safety and Well-being Assessment (SWA).[64] If a SWA was found to be proven or substantiated, then the Department could either take no action; provide intensive family support; or apprehend the child using the care and protection provisions of the *Children and Community Services Act 2004* (CCS Act).[65]

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[57] Exhibit 1, Tab 18, Deceased's Inpatient notes (31.08.18)
[58] Exhibit 1, Tab 18, Deceased's Inpatient notes (01.09.18)
[59] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), p2
[60] Exhibit 1, Tab 4, PCH - Death notification
[61] Exhibit 1, Tab 12, Letter - Dr L Cuddeford and Dr M Princehorn on behalf of the Clinical team (18.08.18)
[62] Exhibit 1, Tab 10, Report - Dr M Princehorn (29.11.18), p2
[63] Exhibit 1, Tab 18, Deceased's Inpatient notes (31.08.18)
[64] See for example: ts 01.11.19 (Geddes), p22
[65] ts 01.11.19 (Geddes), p27

42. SWA's have recently been discontinued. Instead, the Department now conducts Child Safety Investigations into to allegations of harm. Within a 30-day period, child protection workers are expected to establish whether harm has occurred, or is likely to occur, and whether the child's parent or guardian is capable of protecting the child.[66]

Contact with the Department: 2013 - 2016

43. The Department's involvement with the deceased began less than four weeks after his birth. On 25 September 2013, staff at the Child Protection Unit at Princess Margaret Hospital reported concerns regarding his mother's poor attendance at the hospital to care for him and her exposure to family and domestic violence.[67]

44. On 27 November 2013, the Department commenced SWA with respect to the deceased. The concerns were that the deceased's mother had limited contact with him whilst he was in hospital, she had allegedly resumed a relationship with a previous partner who was known to have been violent towards her and it was thought that she may resume drinking alcohol.[68]

45. When spoken to, the deceased's mother advised she was seeing a family violence counsellor, had obtained a violence restraining order against her former partner and had resumed visiting the deceased in hospital. The SWA was closed on 14 February 2014 on the basis that the deceased had not suffered neglect and was not likely to suffer neglect.[69]

46. A further SWA was initiated on 18 December 2014 due to allegations that the deceased's mother was using illicit substances, was experiencing suicidal ideation and had threatened to harm the deceased. On investigation, it was found that the deceased's mother had a strong bond with the deceased and was prioritising his needs. She had engaged with a number of services and her mental health appeared stable. It appeared that the allegations may have been made in a "*conflictual context*" by members of her extended family and the SWA was closed on 23 February 2015.[70]

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[66] ts 01.11.19 (Geddes), pp36-37
[67] Exhibit 1, Exhibit 1, Tab 9D, Report - Ms N Leggett (30.10.19), pp1-2
[68] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p6
[69] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p6
[70] Exhibit 1, Exhibit 1, Tab 9D, Report - Ms N Leggett (30.10.19), pp4-5

47. In 2016, the Department had five interactions with the deceased's mother relating to child protection issues, family support and financial support. No SWA's were undertaken in that year.[71]

Contact with the Department: 2017 - 2018

48. In mid-2017, significant concerns were raised with respect to the deceased's safety. Staff at PCH reported that the deceased was missing key health appointments and that "*such neglect would diminish* [the deceased's] *quality of life and shorten his life*".[72]

49. At the inquest, Dr Princehorn agreed that it would obviously be better if children like the deceased attended all health appointments regularly. He also noted that where there was a pattern of non-attendance, this could have quite a significant impact on a patient's health. This was because clinicians do not have the opportunity to monitor issues like nutrition or respiratory status.[73]

50. Dr Princehorn noted that from December 2014 to July 2018, the deceased attended 23 health appointments (three of which were rescheduled) and failed to attend 12 appointments.[74] He said that this was "*not terribly unusual for some of our families*".[75]

51. From 23 August 2017 onwards, the Department began actively managing the deceased's case. In order to increase her capacity and encourage her to prioritise the deceased's needs, his mother was referred to a number of services and specialist agencies.[76]

52. Unfortunately, she frequently cancelled appointments with these services and a SWA was completed in relation to medical neglect of the deceased. Despite the support provided to the deceased's mother from a number of agencies and services as well as a mental health worker, the deceased's attendance at medical and allied health appointments between March and August 2017 deteriorated.[77]

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[71] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p7
[72] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p7
[73] ts 01.11.19 (Princehorn), p14
[74] Exhibit 2, List of appointments (08.12.14 - 17.07.18)
[75] ts 01.11.19 (Princehorn), p13
[76] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p7
[77] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p7

53. After consulting with a range of agencies that had involvement with the deceased's mother, the Department concluded that although she was a loving mother who wanted the best for the deceased, she had difficulty meeting his complex needs without family support. Further, the deceased's shortened life expectancy was exacerbating her mental health issues.[78]

54. The deceased's mother agreed to engage with the Department and in-home support was provided. A safety plan, aimed at ensuring the deceased's attendance at health appointments was also agreed to. On that basis, the SWA was closed on 10 October 2017 with the alleged neglect not substantiated.[79]

55. On 14 November 2017, a further SWA was commenced after the deceased's mother: "*failed to demonstrate sufficient progress to ensure that* [the deceased's] *medical needs were met*". There was an agreed view that the deceased responded well to his mother's nurturing and departmental staff observed positive interactions between them during visits on several occasions. No indicators of abuse were noted during those visits.[80]

56. The deceased's mother acknowledged she was experiencing difficulties coping with the deceased's complex needs, whilst also caring for her daughter. On 1 March 2018 the SWA was approved on the basis that deceased was at likely risk of neglect. The factors relevant to that decision were:

i. he had missed five essential medical appointments at PCH since September 2017 and had also missed occupational therapy and physiotherapy appointments and this was likely to increase his pain and associated health complications; and

ii. he had been admitted to PCH on 31 January 2018 with weight loss following a paediatric review. This would have been established earlier, had he attended medical appointments regularly.[81,82]

[78] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), pp7-8
[79] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p8
[80] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p8
[81] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p8
[82] Exhibit 1, Tab 9D, Report - Ms N Leggett (30.10.19), pp8-9

57. As a result of the substantiated SWA, child-centred family support was initiated under section 32(1)(a) of the *Children and Community Services Act 2004* (CCS Act). For three months, departmental staff provided intensive support to the deceased's mother, in conjunction with PCH and other services. The plan was that the Department would withdraw support when it was safe to do so.[83]

58. However, in March 2018, the deceased's mother began a relationship with a partner who subjected her to severe levels of family and domestic violence. The deceased was the subject of 14 domestic violence incident reports in which she was alleged to have been the victim of sexual and physical assaults and been forcibly injected with amphetamines.[84]

59. As previously noted, the deceased was an inpatient at PCH from 21 March 2018 to 29 March 2018 and again from 30 April 2018 to 05 June 2018.[85] However, there was a period from 30 March 2018 to 29 April 2018, when the deceased was potentially at serious risk of neglect and/or harm, whilst his mother remained with her violent partner. In passing, I note that the deceased's mother had told the Department that she had not reported numerous other historical family and domestic violence incidents relating to her partner, meaning that her domestic situation was worse than the domestic violence incident reports suggested.[86]

60. In any event, a further SWA was initiated on 21 May 2018, with respect to a family and domestic violence incident witnessed by the deceased's sister. There were also concerns about this child's safety due to the risk of sexual abuse by the deceased's partner. The deceased had not witnessed the incident because he was an inpatient at PCH at the relevant time.[87]

61. Although the Department scheduled four safety plan meetings during May 2018, the deceased's mother cancelled all of them. An attempt was made to contact the deceased's partner, but he failed to engage. Attempts were also made to refer the deceased's mother to culturally appropriate services, but she did not maintain contact with these services.[88]

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[83] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p9
[84] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p9
[85] PCH Discharge summaries, attached to email to the Court from State Solicitor's Office (01.11.19)
[86] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p9
[87] Exhibit 1, Tab 9D, Report - Ms N Leggett (30.10.19), pp10-11
[88] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), pp9-10

62. By this stage, the Department had determined that the deceased's mother's mental health had deteriorated. She had failed to engage with the Department to discuss safety planning with respect to her daughter, and she had become increasingly hostile towards departmental workers.[89]

63. On 2 August 2018, the Department substantiated that both the deceased and his sister were neglected and were likely to be harmed by exposure to family and domestic violence. Both the deceased and his sister were taken into provisional care and protection, pursuant to section 37 of the CCS Act. By that time, the deceased was an inpatient at PCH.[90]

Comments on the Department's involvement

64. At the Inquest, Mr Geddes, properly conceded that, with the benefit of hindsight, the Department's failure to provide more intensive family support to the deceased's mother in March 2018 was a "*missed opportunity*".[91] I agree with that assessment.

65. In March 2018, the deceased's mother had embarked on a relationship with a person who allegedly exposed her to horrendous domestic and family violence and her mental health had deteriorated. In those circumstances, it is difficult to see how she would have been able to provide a safe environment for the deceased, or his sister.

66. Given the fact that the Department was aware of the deceased's mother's own childhood trauma and her mental health issues, she should have been provided with intensive family support, as she had been in August 2017.

67. Although the deceased's mother had previously failed to engage with the services she was referred to, she was clearly struggling to provide the care that the deceased's complex needs required and she should have been better supported. Intensive support from the Department may have had a positive impact, particularly if the deceased's mother had also been supported to extricate herself from her violent relationship.

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[89] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p10
[90] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p10
[91] ts 01.11.19 (Geddes), p34

68. In July 2018, the Department commissioned the Wungenning Moort Aboriginal Corporation to provide an intensive in-home support service to vulnerable families with a focus on safety, family support and parenting skills. The service aims to prevent children entering out-of-home care and Mr Geddes said it could have provided useful and culturally appropriate support to the deceased's mother.[92] In this case, she was not referred to the service because by July 2018, the deceased was either an inpatient at PCH,[93] or was receiving respite care at the Ability Centre (which provides residential support to clients like the deceased). The deceased's sister had, by this time, been placed in out-of-home care.[94]

69. I accept that apprehension of children is a last resort, except where the situation is so extreme that this is the only possible option. I also accept that the Department has to weigh up numerous factors in determining whether to take care and protection action and that the decision is complex. Nevertheless, Mr Geddes agreed that, with the benefit of hindsight, care and protection action could have been considered more actively by the Department in March 2018.[95]

Improvements to Department's family support

70. In have already referred to several improvements the Department has made to its service delivery. Two further enhancements are:

i. *Interaction tool*: introduced in July 2017, this tool helps child protection workers determine whether to intervene in a case where concerns about a child are reported.

ii. *Safe and Together*: a project aimed at improving child protection responses to family and domestic violence will incorporate the *Safe and Together* model. This child-centred approach to managing care arrangements for children exposed to family and domestic violence seeks to: identify harmful behaviours by perpetrators; set measurable safety goals for behavioural change; and work with families and other agencies to support safety and accountability. Preparation for its implementation is currently underway.[96]

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[92] ts 01.11.19 (Geddes), p34 & Exhibit 1, Tab 9D, Report - Ms N Leggett, p13
[93] PCH Discharge summaries, attached to email to the Court from State Solicitor's Office (01.11.19)
[94] Exhibit 1, Tab 9A, Report - Ms J Tang (01.03.19), p9
[95] ts 01.11.19 (Geddes), p35
[96] Exhibit 1, Tab 9D, Report - Ms N Leggett, p13

CAUSE AND MANNER OF DEATH

71. On 5 September 2018, a forensic pathologist (Dr Moss) recommended that the cause of the deceased's death could be ascertained without the necessity of an internal post mortem examination of the deceased's body. That recommendation was accepted on 5 September 2018.[97]

72. Dr Moss conducted an external examination and found the deceased had spine and limb deformities and low muscle mass in keeping with his known medical conditions.[98]

73. Toxicological examination confirmed the presence of a number of medications in the deceased's system that were consistent with his hospital care.[99,100]

74. Dr Moss expressed the opinion that the cause of death was aspiration pneumonia, with terminal palliative care, in a male child with complex medical co-morbidities including congenital myopathy and arthrogryposis.[101]

75. I accept and adopt that conclusion.

76. Given the circumstances of the deceased's death, I find that death occurred by accident.

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[97] Exhibit 1, Tab 7, Pathologist's recommendation for an external post mortem (05.09.18)
[98] Exhibit 1, Tab 7, Post Mortem Report, p3
[99] Exhibit 1, Tab 8, Toxicology Report
[100] Exhibit 1, Tab 7, Supplementary Post Mortem Report, p1
[101] Exhibit 1, Tab 7, Supplementary Post Mortem Report, p1

CONCLUSION

77. The deceased was a 5-year old boy who was born with several serious congenital conditions. He died from aspiration pneumonia at PCH on 1 September 2018.

78. During the inquest, it was clear that the deceased was dearly loved by his mother. However, as a result of the limitations imposed on her by her own childhood trauma and her mental health issues, she was unable to consistently provide him with the level of care that his complex needs demanded.

79. The deceased's medical issues imposed a heavy burden on his mother who also had the care of a younger child. In March 2018, she had entered a relationship that was reportedly characterised by appalling levels of family domestic violence. In those circumstances, the Department's intervention at that point, should clearly have been more robust.

80. As the Department properly conceded, in March 2018, the deceased's mother should have been provided with intensive family support. The deceased's safety could then have been more closely monitored, and if appropriate, apprehension action could have been considered more actively.

81. In this case, given the findings I have made with respect to the cause and manner of the deceased's death, the outcome in this case would not have been any different had the Department's support of the deceased and his family been more comprehensive. However, I sincerely hope that the improvements the Department has made to its practices will lead to an enhanced child safety response.

82. As I have already observed, the deceased's treating team at PCH did everything they could to improve the deceased's quality of life during those periods when he was in their care.

MAG Jenkin
Coroner
21 November 2019