JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Barry Paul King, Deputy State Coroner
HEARD	**:**	11 DECEMBER 2019
DELIVERED	**:**	7 OCTOBER 2020
FILE NO/S	**:**	CORC 20 of 2015
DECEASED	**:**	JM

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Sergeant L Housiaux assisted the Deputy State Coroner.

Ms R Hartley (State Solicitor's Office) appeared on behalf of the Department of Communities and the Western Australia Country Health Service.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Barry Paul King, Deputy State Coroner, having investigated the death of **JM** with an inquest held at Perth Coroners Court, Fitzroy Crossing Police Station, Police Station Courtroom, Lot 68 McLarty Street, Fitzroy Crossing, on 11 December 2019, find that the identity of the deceased person was **JM** and that death occurred on 9 July 2015 at Fitzroy Crossing Hospital, from dehydration complicating diarrhoea (aetiology unknown) in the following circumstances:*

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NON-PUBLICATION ORDER UNDER SECTION 49 OF THE *CORONERS ACT 1996*

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

INTRODUCTION

1. JM was 10 weeks old. He lived with family carers (foster parents) in a community about 160 km from Fitzroy Crossing. He was developing well with no health or care concerns.

2. JM received his first immunisations on 1 July 2015. On 8 July 2015, he became unwell with fever and diarrhoea. His foster parents provided paracetamol, fluids and constant care overnight, but his condition deteriorated. He developed difficulty breathing and became unresponsive. In the early hours of 9 July 2015 he was taken to Fitzroy Crossing Hospital, but he could not be revived.

3. Forensic pathologist Dr J McCreath found that JM had died from dehydration complicating diarrhoea, the cause or origin of which was unknown.

4. At the time of his death, JM was in the care of the Chief Executive Officer of the Department of Communities, Child Protection and Family Support (the Department),[1] so he was a 'person held in care', and his death was reportable under the *Coroner's Act 1996* (the Act).[2] An inquest was mandatory,[3] and the Coroner was required to comment on the quality of the supervision, treatment and care that JM received while in that care.[4]

5. On 1 February 2018, Coroner Malley investigated JM's death and, without holding an inquest, made an administrative finding in relation to JM's death. At the time of the investigation, Coroner Malley was not aware that JM was a person held in care.

[1] Exhibit 1.1.23 1
[2] Section 3 the Act
[3] Section 22(1)(a) the Act
[4] Section 25(3) the Act

6. With Coroner Malley's consent, on 26 February 2018, the State Coroner set aside his finding and ordered that an inquest be held.

7. On 11 December 2019, I held an inquest at the Fitzroy Crossing Courthouse. The inquest focused on the standard of JM's care and the Department's and WA Country Health Service's (WACHS) involvement in JM's care leading up to his death.

8. The documentary evidence adduced at the inquest included a brief of evidence[5] that contained reports from the investigating police officers, statements from JM's foster parents and medical practitioners, correspondence and reports from the Department, the Department of Health and WACHS, hospital records, and an opinion from senior consultant paediatrician Professor S P Nair.

9. Also included in the documentary evidence was an extract from the Ombudsman Western Australia (the Ombudsman) Annual Report 2018-2019.[6]

10. Oral evidence was provided by (in order of appearance):

    a. Nurse Rebecca Crozier, clinical nurse specialist;[7]

    b. Ms Fiona Fisher, Regional Executive Director, Kimberley Region, Department of Communities;[8]

    c. Dr Wesam Abujalala, senior registrar;[9] and

    d. Professor Nair.

11. I found that the quality of the supervision, treatment and care that JM received while he was in care was reasonable and appropriate in the circumstances, and I am satisfied that improvements implemented in the community in which JM lived will reduce the likelihood of another child dying in similar circumstances.

[5] Exhibit 1.1.1 to 1.1.29
[6] Exhibit 2
[7] ts 5-9
[8] ts 9-17
[9] ts 84 - 101

JM

12. JM was born in Broome on 29 April 2015 following an uncomplicated birth. JM's parents could not care for him, so the Department placed him with foster parents. His mother had access to visit him, and she provided breastfeeds and expressed milk.[10]

13. JM lived with his foster parents and their two children in a remote community where a number of his extended family members also resided and provided support.[11]

EVENTS LEADING UP TO JM'S DEATH

14. JM received his first immunisations on 1 July 2015. He was well, his foster parents consented, and the side-effects were explained to them. No reaction was noted after the immunisation, but JM's foster mother was provided paracetamol at her request.[12]

15. At about 6.00 am on 8 July 2015, JM's foster father woke to go to work while JM was asleep with his foster mother. At 2.00 pm, JM's foster father came home for lunch and made up JM's formula, gave it to him, and returned to work. JM's foster mother remained with JM.[13]

16. When JM's foster father returned from work later that afternoon, JM's foster mother and foster sister were looking after JM. At about 6.00 pm, JM's foster mother noticed that JM appeared sick. His eyes looked weary, and his head was warm. He appeared to have diarrhoea. His foster mother thought that he had either a reaction to the immunisation or an infection, so she gave him paracetamol.[14]

17. That evening, JM was unsettled and in apparent pain. He cried continuously. His foster mother gave him paracetamol every three or four hours and formula each time he opened his bowels. She walked around with him in her arms and eventually he would settle for a while so that she

[10] Exhibit 1.1.17 3-7
[11] Exhibit 1.1.23 3-4
[12] Exhibit 1.1.17 Patient Summary 7-8
[13] Exhibit 1.1.10 1-2
[14] Exhibit 1.1.9 1-2

could put him down, but she would have to pick him up again to try to settle him. At 5.00 am on 9 July 2015, JM's foster mother woke up his foster father to look after him so that she could get some sleep.[15]

18. JM's foster father stated that, when he took over JM's care, JM was still crying and his hands were cold, but his chest felt normal. He could not settle, so his foster father woke up JM's foster mother and called the Fitzroy Crossing Hospital. He was told to bring JM to hospital, but JM's foster father said that he could not get to the hospital any time soon. He was then told that JM could see a doctor who would be visiting the community at about 8.00 am.[16]

19. At about 7.30 am, JM's foster father noticed that JM was not breathing properly and not responding to him, so he called the hospital again. He spoke with Nurse Crozier, who told him that an ambulance would be sent and asked him to drive JM towards Fitzroy Crossing to meet the ambulance part-way. Nurse Crozier and a hospital orderly then started towards the community in an ambulance. [17]

20. JM's foster parents got into their car with JM and had travelled about 3 km when they noticed that JM was not breathing. They then administered CPR as they continued to travel to meet the ambulance.[18]

21. At 8.25 am, Nurse Crozier and the orderly met up with JM's foster parents about 20 km from the community turn-off. JM's eyes were wide open and dry, and his pupils were fixed and dilated. His mouth was open, and his tongue was very dry, and he displayed no signs of life. His skin was cool, his nail beds were pale, and his abdomen was warm. Nurse Crozier administered CPR and JM's foster parents got into the ambulance for the trip back to Fitzroy Crossing Hospital.[19]

22. Upon arrival at the hospital, JM was taken straight into the resuscitation room where doctors and nurses were waiting, and a paediatrician was on

[15] Exhibit 1.1.9 2
[16] Exhibit 1.1.10 2
[17] Exhibit 1.1.10 3, Exhibit 1.1.11 1
[18] Exhibit 1.1.10 4
[19] Exhibit 1.1.11 2-4

video link from Broome, but JM could not be revived.[20] Dr Abujalala pronounced JM's life extinct at 9.21 am.[21]

CAUSE OF DEATH AND HOW DEATH OCCURRED

23. On 15 July 2015, forensic pathologist Dr McCreath performed a post mortem examination and found a well-nourished male infant with a sunken fontanelle and minimal tan fluid throughout the gastrointestinal tract but no solids.[22]

24. Toxicology, neuropathology, microbiology, virology and biochemistry investigations showed evidence of dehydration and recent immunisation but no specific abnormalities. Dr McCreath assessed JM's medical history and concluded that he had not had neonatal abstinence syndrome and that his immunisations had not contributed to his death.[23]

25. Paediatric and perinatal pathologist Dr Disna Abeysuriya reviewed JM's forensic and medical history and concluded that 'overall there is no anatomical cause found contributing to death. However, taken together with the history and other findings … it is possible that there was dehydration secondary to diarrhoea, although the physical findings may be subtle or nonspecific'.[24]

26. Dr McCreath formed the opinion that the cause of death was dehydration complicating diarrhoea (aetiology unknown).[25] That opinion was supported by Professor Nair.[26]

27. On the basis of the evidence available, I find that JM died from dehydration complicating diarrhoea from an unknown cause and that death occurred by way of natural causes.

[20] Exhibit 1.1.11 4-5
[21] Exhibit 1.1.5
[22] Exhibit 1.1.6 1
[23] Exhibit 1.1.2 6
[24] Exhibit 1.1.6 Letter dated 19/5/2017
[25] Exhibit 1.1.6 1
[26] Exhibit 1.1.22 13

JM'S PLACEMENT INTO CARE

28. JM's father had no involvement in JM's life, and JM's mother was unable to take care of him due to a history of mental illness. Various traumas she had experienced from her childhood had resulted in a schizophrenic disorder and involuntary admissions to mental health care facilities, including at the time of her pregnancy.[27]

29. JM's extended family participated in the selection of his carers and the assessment of placement in the community. On 1 May 2004, JM was cleared for discharge by paediatrics with no health concerns noted[28] and on 4 May 2015 he was placed with his foster parents in a remote community where JM's mother and a number of other significant family members would be able to provide support if required.[29]

30. At the time of JM's placement, a registered nurse visited the community four days per week for five hours each day, and a doctor visited the community three times per month. Professional health workers from Fitzroy Crossing had access to the community by air and road.[30]

31. The Department carried out an assessment of the suitability of JM's placement in the community and concluded that JM's health, safety and wellbeing were not compromised by a remote placement.[31]

32. Ms Fisher told the inquest that, wherever possible, the Department adheres to the Aboriginal Child Placement Principle, and JM's placement was 'top of the line' since he was placed with his Aboriginal family in his mother's community.[32]

33. Ms Fisher said that there was no indication of a reason to worry about JM's placement in a remote community. She said that the Department and the Health Department worked together in relation to suitable care-givers, and there was no sense that JM needed to be closer to medical care.[33]

[27] Exhibit 1.1.23 1
[28] Exhibit 1.1.23 5
[29] Exhibit 1.1.23 4
[30] Exhibit 1.1.23 4
[31] Exhibit 1.1.23 4
[32] ts 10
[33] ts 11

34. At the inquest, Professor Nair also agreed that, in the circumstances, it was appropriate to place JM into care.[34]

CARE PROVIDED TO JM

The Department

35. Despite the extensive consultation measures taken by the Department in relation to JM's placement, an investigation by the Ombudsman found that a number of steps were not taken. The Ombudsman made three recommendations for the Department to take steps to ensure compliance with practice requirements and documented plans regarding placement, monitoring and health care planning in relation to the placement of children into care.[35]

36. In its response to the Ombudsman's preliminary review and recommendations, the Department acknowledged that:

    a. family carers are increasingly becoming the main carer group for children in need of out-of-home care and that better induction processes and strategies to support family carers was warranted and was underway as part of the Out-of-Home Care Reform; and

    b. Health Care Planning was not formally initiated by the Department in this case and should have been formally initiated despite the extensive involvement of medical professionals and the fact that JM was medically cleared for placement.[36]

37. In oral evidence, Ms Fisher said that the Department had taken steps to implement the Ombudsman's recommendations. She said that the Department had already updated the case practice manual, launched out-of-home care reform, and had enhanced training and quality assurance processes for assessments.[37] Ms Fisher said that the Department had also:

    a. implemented a needs-assessment tool to help assess specific health needs of children in order to provide better care and better services;

[34] ts 27
[35] Exhibit 1.1.23 5
[36] Exhibit 1.1.23 5
[37] ts 13

b. included quality standards to ensure that physical and mental development is met; and

c. formalised recording practise, specifically for health care plans.[38]

38. Ms Fisher also said that, while JM had lots of interaction with the Department of Health, the Department had not formally commenced his health planning, but she agreed that his actual day-to-day health needs were being met.[39]

Foster Parents

39. At the inquest, both Ms Fisher[40] and Professor Nair[41] agreed that JM's foster parents cared for him well. They were working with the Department, had extended family support and were taking JM to his regular infant medical check-ups. As a result, JM was thriving and 'growing beautifully' with no concerns being raised about his health or the care provided by his carers.[42]

40. JM's foster mother stated that he was a healthy baby who did not require medication prior to this incident.[43]

41. When JM became unwell and developed diarrhoea, his foster parents tended to him immediately. Professor Nair noted that diarrhoea in babies this young can cause significant, rapid fluid loss, and often the fluid loss is so great that attempts to keep up the rehydration with oral fluids can be quite difficult.[44]

[38] ts 14
[39] ts 14
[40] ts 11
[41] ts 27
[42] Exhibit 1.1.23 2 1.1.22 9
[43] Exhibit 1.1.9 9-9
[44] Exhibit 1.1.22 11

Medical Care

42. The evidence at the inquest showed that JM received appropriate medical attention in relation to his birth and neonatal care, his developmental reviews and immunisations, his transport by ambulance to the hospital and the emergency department care he received upon arrival.[45]

CONCLUSIONS ABOUT JM'S CARE AND THE DEPARTMENT'S INVOLVEMENT

43. While there were some shortcomings in the Department's adherence to compliance practices, these have been acknowledged and accepted, and steps have been taken by the Department to address them. It is clear that the Department's interactions with JM, his mother and her family were extensive and that the decision to place JM into care was appropriate.

44. The evidence also shows that JM's foster parents provided him with the care he required and that he was happy and healthy. Tragically, he became unwell and quickly succumbed to dehydration, something that still affects a large portion of young infants.

45. I am satisfied that the care, supervision and treatment provided to JM by the Department was of an appropriate standard.

COMMENTS ON CHANGES AND IMPROVEMENTS

Placement into care

46. As noted above, the Department has accepted the Ombudsman's recommendations in relation to compliance with child placement processes and has taken steps to implement various measures to comply with those recommendations.[46]

Education, training and availability of medical assistance

47. Both Dr Abujalala and Professor Nair noted the dangers of dehydration in infants from diarrhoea. Professor Nair stated that diarrhoeal illness is still

[45] Exhibit 1.1.22 8-12
[46] ts 13-14

the second leading cause of death in children under five years of age in the world and that rehydrating infants under three months is particularly difficult.[47]

48. Professor Nair said that, while programs relating to the importance of monitoring growth, providing oral rehydration, breastfeeding and immunisations have been successful, more education was needed about dehydration risks to babies under three months of age, recognition of early signs of dehydration, and seeking early medical intervention.[48]

49. Professor Nair said that nursing staff can provide immediate safe rehydration of young infants under three months by inserting a nasogastric tube, and it was a matter of upskilling, educating and training remote nursing staff.[49]

50. Professor Nair added that education about the risk of common but potentially fatal infant illnesses should ideally be provided at the child health clinics because that's where the contact with the parents and carers is in the early stages and where videos, posters and pamphlets can be shown and discussed because this is what sticks in parents' minds.[50]

51. Dr Abujalala also said that in remote communities, the most successful education allows parents and carers to see visual examples of what to look for. So, for dehydration, showing parents and carers what a depressed fontanelle, dry mucus and dry tongue look like, and using flyers and posters would help to show the symptoms and train them.[51]

52. Following the inquest, the Department advised that:

    a. WACHS had undertaken to review the education provided by remote area nurses to remote communities and to develop any required materials regarding hydration; and

[47] Exhibit 1.1.22 11
[48] ts pp 30-31
[49] ts 35 – 36
[50] ts 32 – 34
[51] ts 22

b. the Department undertook to make access to the WACHS resources available in their Casework Practice Manual and to include advice to child protection workers to provide to parents and carers of infants in remote communities in the Kimberley Districts.[52]

53. WACHS has confirmed that, in August 2018, JM's community clinic transitioned to a remote area clinic with a residential nursing post. Remote area nurses now reside in the community, providing a five days per week service and 24 hours/seven days per week emergency after-hours care for residents.

54. On 2 October 2020 WACHS provided further information to the court in relation to the education, including signs and symptoms of dehydration, that is given to all mothers shortly after a baby is born. That information does not appear to include the types of videos, flyers and posters aimed at parents and carers in remote communities that were suggested by Professor Nair and Dr Abujalala.[53]

55. As to Professor Nair's evidence in relation to the use of nasogastric tubes by nurses, WACHS advised that remote area nurses are trained annually in paediatric advanced life support, which includes the use of nasogastric tubes. Remote area nurses are also required to assess infants for hydration when they attend clinics.[54]

56. In these circumstances, while there is some further work to be done by WACHS and the Department in relation to their undertakings, I am satisfied that the risk of another infant dying in a situation similar to JM's has been greatly reduced.

CONCLUSION

57. It is a terrible irony that JM had the benefit of placement with extended family members who were willing and able to give him the nurturing he required, but that he still died from a condition which would have been easily treatable had the seriousness of it been recognised earlier.

[52] Letter from the Department of Communities dated 15 April 2020
[53] ts 35-36
[54] Email from Ms Hartley dated 2 October 2020

58. The Department's and WACHS' efforts to ensure that parents and carers of children in remote areas of Western Australia are able to recognise and take steps to overcome dehydration in infants are commendable, but I suggest that the proposed visual aids also be developed and used.

B P King
Deputy State Coroner
7 OCTOBER 2020