JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	4 FEBRUARY 2021
DELIVERED	**:**	11 FEBRUARY 2021
FILE NO/S	**:**	CORC 963 of 2019
DECEASED	**:**	CHILD T

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W Stops appeared to assist the coroner.

Ms M Hemsley, (State Solicitor's Office) appeared on behalf of the Department of Communities.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of a male child referred to as **Child T** with an inquest held at Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth, on 4 February 2021 find that the death of **Child T** occurred on or about 13 July 2019 at a home in Port Kennedy, from pneumonia in association with bronchiolitis in the following circumstances:*

Table of Contents

INTRODUCTION **3**
CHILD T **4**
Overview 4
Behaviours 4
Overview of medical issues 4
THE DEPARTMENT'S INVOLVEMENT **5**
Summary 5
Concerns for Child T's welfare 6
Care and protection order 9
MEDICAL ISSUES **11**
Immunisations and vaccinations 11
GP Appointments 13
Comments on medical care 15
EVENTS LEADING TO CHILD T's DEATH **16**
COMMENTS ON CHILD T's CARE **19**
Should the Department have intervened earlier? 19
Comments on Ms C's care of Child T 20
CAUSE AND MANNER OF DEATH **23**
Post mortem examination 23
Cause and manner of death 23
CONCLUSION **24**

SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make the following order pursuant to section 49(1)(b) of the *Coroners Act 1996* (WA): There be no reporting or publication of the deceased's name and any evidence likely to lead to the child's identification. The deceased is to be referred to as "Child T".

Order made by: MAG Jenkin, Coroner (04.02.21)

INTRODUCTION

1. Child T died from pneumonia in association with bronchiolitis on 13 July 2019. He was two years and three months of age. At that time, he was in the care of the Director General of the Department of Communities (Department) and he and his older sibling had been placed with a foster carer.[1]

2. Accordingly, immediately before his death, Child T was a "*person held in care*" and his death was therefore a "*reportable death*".[2] In such circumstances, a coronial inquest is mandatory.[3] Where, as here, the death is of a person in care, I must comment on the quality of supervision, treatment and care the person received.[4]

3. The documentary evidence at the inquest consisted of one volume and included medical records and a report from the Department. The inquest focused on the management of Child T's medical conditions and on the involvement of the Department in his life. The following witnesses gave evidence:

a. Child T's foster carer, (Ms C);
b. Dr Vernon Thorpe (Child T's general practitioner); and
c. Mr Andrew Geddes (representing the Department).[5]

4. On the basis that it would be contrary to the public interest, the State Coroner made a non-publication order with respect to Child T's name on 27 November 2020. I varied that order on 4 February 2021 to provide that the deceased should be referred to as "Child T". The terms of the varied order are set out on the previous page.[6]

5. In this Finding, so as to protect Child T's identity, I have chosen to refer to Child T's mother as "AB", his father as "CD" and his foster carer as Ms C. No disrespect is intended to any person.

---

[1] Exhibit 1, Tab 23, Report - Ms J Tang, Department of Communities (27.11.20)
[2] Section 3, *Coroners Act 1996* (WA)
[3] Section 22(1)(a), *Coroners Act 1996* (WA)
[4] Section 25(3), *Coroners Act 1996* (WA)
[5] Mr Geddes is the Department's Regional Executive Director, South Metropolitan Region
[6] Section 49(1), *Coroners Act 1996* (WA)

CHILD T

Overview[7]

6. Child T was born at Rockingham General Hospital (RGH) at 35 weeks and four days gestation on 30 March 2017. His birth was reportedly uncomplicated and he weighed 2.7 kg. At the time of his death, his weight was within the normal range.

Behaviours

7. According to Ms C, Child T had several behavioural issues, and both he and his older sibling were reviewed monthly by a caseworker and a psychologist. A departmental report dated 5 December 2018, noted that:

> [Child T] has been exposed to family and domestic violence and parental drug abuse prior to coming into care however it is unknown what impacts this has had on [Child T's] emotional and behavioural development.
>
> [Child T] has recently started to demonstrate tantrums however the Carer is able to co-regulate [Child T] and respond to his needs appropriately with "time in" strategies. [Child T] is eager to absorb any and all information from his environment and will seek out his Carer for reassurance and emotional support. [Child T] responds to firm boundaries and routine. [Child T] will take himself to bed each night when prompted by his Carer.[8]

Overview of medical issues

8. Child T appears to have been a relatively healthy child, although he had bouts of vomiting and diarrhoea and several upper respiratory tract infections. He also had several nose bleeds, which seems to have been related to his habit of picking his nose.

9. Child T's foster carer took him to see doctors on a regular basis and according to the documentary evidence, she appears to have carefully followed all medical advice.

---

[7] Exhibit 1, Tab 23, Report - Ms J Tang, Department of Communities (27.11.20), pp1-4
[8] Exhibit 1, Tab 26C, Care Arrangement Referral (05.12.18), p3

10. On 1 November 2018, Child T suffered "*windburn*" while attending a school sports carnival where Ms C's son was competing. Ms C took Child T to a pharmacy and was advised to apply Aloe Vera gel to the affected areas. On 13 November 2018, the Department's Duty of Care Unit concluded Ms C had not been negligent in respect of this incident and that she had taken appropriate action to treat the windburn.[9]

THE DEPARTMENT'S INVOLVEMENT

Summary[10]

11. Child T was taken into "*provisional protection*" pursuant to the *Children and Community Services Act 2004* (WA) (CCSA) on 23 August 2018 on the basis that there were reasonable grounds to suspect there was an immediate and substantial risk of harm to his wellbeing on the grounds of exposure to emotional abuse and family and domestic violence.[11]

12. Child T and his sibling were placed into foster care and the Children's Court of Western Australia (Children's Court) made a protection order in favour of the Department on 12 March 2019. Child T died on or about 13 July 2019 at his foster carer's home.

13. Both Child T's parents had contact with the Department when they were children and both had criminal records. In June 2018, Child T's mother (AB) was convicted of possession of cannabis and drug paraphernalia.

14. Meanwhile, between 2012 and 2018, Child T's father (CD) was convicted of 14 offences including drug offences relating to the possession of methylamphetamine and MDMA (i.e.: Ecstasy).[12]

15. CD was also named as a person of interest in relation to six family and domestic violence reports between 2015 and 2018.

---

[9] Exhibit 1, Tab 26C, Email Ms A Craig (Duty of Care Unit), (13.11.18)
[10] Exhibit 1, Tab 23, Report - Ms J Tang, Department of Communities (27.11.20), pp1-4
[11] s 37, *Children and Community Services Act 2004* (WA)
[12] MDMA is short for 3,4-Methylenedioxymethamphetamine, a psychoactive drug used for recreational purposes

Concerns for Child T's welfare[13]

16. On 9 May 2018, Child T's uncle contacted the Department to raise his concerns about the welfare of Child T and his sibling. The uncle was concerned that the children were being exposed to family and domestic violence and parental drug use. The uncle said he had witnessed Child T's parents using methylamphetamine and cannabis and remaining awake for extended periods, before sleeping "*for days*".

17. On 22 May 2018, during an appointment at Fiona Stanley Hospital (FSH), AB became extremely emotional (described as teary to angry and threatening staff in a very short timeframe) and disclosed daily cannabis use. Staff had concerns about the family's accommodation situation and a senior social worker at FSH contacted the Department which began an inquiry for neglect and emotional abuse and family and domestic violence on 29 May 2018.

18. Despite the fact that CD appeared to be under the influence of illicit drugs and AB had a black eye during an unannounced home visit on 6 June 2018, the Department closed its investigation on 22 June 2018. The basis for closing the case was that at that time, Child T, his parents and his sibling were all living with Child T's paternal grandmother, who the Department said was "*available to monitor, assist and support AB and CD to ensure the children's needs were being met*".

19. I accept that from the Department's perspective, the apprehension of a child is an action of last resort. In Child T's case, the decision not to apprehend him and his sibling at this point was predicated on Child T's paternal grandmother being able to sufficiently influence the behaviour of AB and CD, so as to ensure the children would be safe.

20. However, other than providing a letter of support for child care for Child T's sibling, the Department did not offer the level of intensive family support and monitoring that this case clearly called for. As Mr Geddes properly conceded, this was a missed opportunity.[14]

[13] Exhibit 1, Tab 23, Report - Ms J Tang, Department of Communities (27.11.20), pp4-8
[14] ts 04.02.21 (Geddes), pp29-30

21. Further concerns about the children's welfare were raised with the Department on 24 July 2018, when a neighbour reported that CD had threatened to kill AB and the children. The neighbour also reported ongoing concerns about CD and his erratic and aggressive behaviour and that both Child T's parents were using illicit drugs.

22. On 30 July 2018, the Department spoke to AB by phone regarding the concerns that had been raised by the neighbour. AB said she had separated from CD after he had hit her around the face with his fists. She said she would make a statement to Police and that she was considering a violence restraining order. AB also told the caseworker that she had no family support and that she and the children were staying with a friend while she looked for private rental accommodation.

23. In the context of the significant concerns which had already been raised about the children's welfare, it is alarming that the Department did not act on the information it received from the neighbour for six days. When the Department did take action, instead of a face-to-face visit with AB at which the children could have been sighted, a caseworker spoke to AB on the phone.

24. No immediate support was offered and AB's assertion that she had separated from CD appears to have been accepted at face value. Mr Geddes agreed that the Department's response to this information was suboptimal and that action to investigate the serious allegations raised by the neighbour should have been taken at an earlier stage.[15]

25. On 2 August 2018, a caseworker spoke to AB who confirmed she had reported CD's alleged assault to the police and would be applying for a violence restraining order. She confirmed that CD had not attended her friend's address and that CD's father would help supervise contact between CD and the children. This suggests that AB was still in contact with CD and in my view, should have been a cause for concern.

[15] ts 04.02.21 (Geddes), p33

26. On 8 August 2018, a caseworker visited CD's mother who confirmed that she was unable to care for the children and that CD was no longer welcome in her home. CD's mother told the caseworker that AB was "*a good mother*" who "*kept the children clean and well fed*". Meanwhile, AB had called the Department to advise that she and the children were homeless. AB declined offers of placement in a refuge and turned down a referral to a service offering support to homeless people, saying should would "*sort things herself*".

27. On 9 August 2018, the Department received a report from Child T's paternal aunt that his parents had said they were planning to relocate to the United Kingdom to "*evade child protection*". On 10 August 2018, AB called the Department to confirm that she had resumed her relationship with CD, and the family were staying at an Airbnb in East Perth. CD was said to have not used illicit drugs for one week, although AB confirmed she was using cannabis to control her anxiety.

28. Despite her earlier assertions to the contrary, the Department was now aware that AB had resumed her relationship with CD, and more importantly that he was living with her and the children. Despite this information, no attempt was made to conduct a home visit to view the children and instead, a safety plan was devised with AB. Under the plan, if CD left the home, AB was to assume he had gone to purchase illicit drugs and was to call a family member who would collect her and the children.

29. On 13 August 2018, a caseworker called AB. Ab said that CD had not been using illicit drugs and she had not needed to implement the safety plan. AB said the family had been staying with the family member she was to contact under her safety plan, but that this person had died the night before. AB said the family could stay at the address for two weeks but thereafter, they would need to find rental accommodation either in Perth or interstate.

30. Although both AB and CD had agreed to meet with a caseworker on 15 August 2018, when they cancelled the appointment on that day, there was no immediate follow up by the Department.

31. On 22 August 2018, a family friend and a worker at a community centre contacted the Department to report further concerns about the welfare of Child T and his sibling. These concerns related to CD's use of methylamphetamine and his violent behaviour towards AB, who a black eye, a chipped front tooth and bruising to her back, ribs, arms and neck. AB said these injuries were the result of assaults on her by CD on 21 August 2018.

32. The family were reported to be homeless and it was said that CD was spending the family's Centrelink payments, meaning that AB was relying on emergency food services to feed the children. A departmental caseworker arranged for AB and the children to be placed in a refuge, but AB left the premises on 23 August 2018, and it was feared she had returned to CD.

33. AB reportedly compromised the safety of the children by telling CD about her movements, including the location of the refuge. Furthermore, AB told a caseworker that she intended to continue her relationship with CD.

Care and protection order[16]

34. On the basis of AB's behaviour and because of ongoing concerns for the welfare of Child T and his sibling, the Department took the children into provisional care on 23 August 2018. The Safety Wellbeing Assessment (SWA), which the Department began after receiving serious allegations from AB's neighbour on 24 July 2018, was completed on 5 September 2018. The result of the SWA was that the likelihood of emotional harm was substantiated.[17]

35. At the time, a SWA was one of the ways that the Department responded to allegations of child neglect, abuse and/or safety concerns. 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 CCSA.[18]

[16] Exhibit 1, Tab 23, Report - Ms J Tang, Department of Communities (27.11.20), pp7-15
[17] ts 04.02.21 (Geddes), p30
[18] ts 04.02.21 (Geddes), pp30-31

36. In passing I note that Child Safety Investigations have replaced SWA's as a means investigating allegations of harm. Under the new arrangements, child protection workers are expected (within 30 days) to determine whether harm has occurred or is likely to occur and whether the child's parent or guardian is capable of protecting the child.[19]

37. Child T and his sibling were placed with a foster carer, Ms C. She had a child of her own and was described as a "*warm and welcoming*" person who had demonstrated her ability to provide a safe, caring and nurturing environment for a child in need of care and protection.[20]

38. Ms C was also described as "*highly motivated and committed*" to becoming a foster carer and had completed the required mandatory preparation training in September 2016.[21] Prior to agreeing to care for Child T and his sibling, Ms C had successfully cared for two other children on separate occasions, each for a period of about nine months.[22]

39. During the period that the children were in Ms C's care, a departmental caseworker maintained contact on a regular basis and Ms C confirmed that the caseworker was available by phone or email as required. The Department also provided respite care for the children on some weekends. Ms C noted that this was welcome because caring for two foster children both of whom had viruses when they came into her care was tiring.[23]

40. The Department's application for a protection order in favour of Child T and his sibling was granted by the Children's Court on 12 March 2019.

[19] ts 04.02.21 (Geddes), p32
[20] Exhibit 1, Tab 24, Report - General foster care assessment (01.11.16), p6
[21] Exhibit 1, Tab 24, Report - General foster care assessment (01.11.16), pp1 & 17
[22] ts 04.02.21 (Ms C), p10
[23] ts 04.02.21 (Ms C), pp10-11

MEDICAL ISSUES

Immunisations and vaccinations[24,25,26,27,28]

41. On 1 October 2018, AB asked the Department to have Child T taken to a GP because he had been sick at their last contact visit and she was concerned his childhood immunisations had not been completed. AB confirmed she had taken the Health Department record books for Child T and his sibling to the Department's Rockingham office. On 4 October 2018, Ms C confirmed that she would arrange to have the vaccinations done at Child T's next appointment with his doctor.

42. On 9 October 2018, AB told the Department that she had been diagnosed with pneumonia as a baby and had relapsed at two years of age. She said was concerned that the same thing would happen to Child T.[29] The Department agreed to arrange for Child T and his sibling to undergo a medical assessment and on 10 October 2018, the children were seen by Dr Thorpe at the Bayside Medical Centre. Dr Thorpe, who has been in general practice for 37 years, noted that there was no record in Child T's Health Department record book that his 12-month vaccinations having been given.

43. On examination, Dr Thorpe found Child T had a cough but his chest was clear. As only a short appointment had been booked that day, there was not enough time for Dr Thorpe to complete the required departmental paperwork and a further appointment was booked for the following day.

44. When Dr Thorpe saw Child T on 11 October 2018, Child T's cough was worse and there were crackling sounds in his lungs that suggested a chest infection. Dr Thorpe prescribed an antibiotic and when he reviewed Child T on 17 October 2018, he noted that Child T's cough had "*virtually disappeared and his chest was now clear*".

---

[24] Exhibit 1, Tab 21, Medicare immunisation history
[25] Exhibit 1, Tab 22, Department of Health Childhood vaccination record
[26] Exhibit 1, Tab 19, Report - Dr M Monroe (23.07.19)
[27] Exhibit 1, Tab 6, Statement - Ms C, paras 14-16
[28] Exhibit 1, Tab 20, Report - Dr V Thorpe (30.07.19) and ts 04.02.21 (Thorpe), pp41-47
[29] See also: Exhibit 1, Tab 12B, Email from AB to Sen. Const. J Robinson (19.10.19)

45. In Western Australia, the Health Department's recommended childhood immunisation schedule for 12-month old infants includes: the MMR vaccine (for measles, mumps and rubella); the Pneumococcal vaccine and the Meningococcal vaccine.[30]

46. On 18 October 2018, the Department contacted the Australian Childhood Immunisation Register requesting information about Child T's vaccination status. Child T's immunisation history statement was provided to the Department on 8 November 2018, and showed that his 12-month immunisations were not up to date.

47. Dr Thorpe next saw Child T on 11 December 2018. During that consultation, Dr Thorpe noted that Child T had only received the Pneumococcal vaccine and so he gave Child T the missing MMR and Meningococcal vaccines. On 8 January 2019, Child T saw Dr Thorpe again in relation to altered bowel movements and Dr Thorpe took the opportunity to give Child T the vaccinations recommended for 18-month old children, namely Varicella and DPTA.

48. Dr Thorpe told the inquest that the eight month delay in Child T receiving the missing 12-month vaccinations may have made him more vulnerable to contracting diseases such as Measles, Mumps or Rubella. However, as I will discuss later in this Finding, the cause of Child T's death was pneumonia in association with bronchiolitis, a viral infection for which there is no vaccine.[31]

49. In that context, Dr Thorpe made the following comment about the effect on Child T's health outcomes of the delayed 12-month vaccinations:

> However, the delay I don't believe put him at more risk of illnesses later. So after the vaccine was given in December (2018), and then, again, the follow-up in January (2019), within two or three weeks of those vaccines, he would have had very good immunity and, certainly, within a month from the vaccine in January (2019) his immunity to measles, mumps, rubella would have been as good as it could get.[32]

[30] See: https://healthywa.wa.gov.au/Articles/A_E/Childhood-immunisation-schedule
[31] 04.02.21 (Thorpe), p45
[32] 04.02.21 (Thorpe), pp44-45

50. For the sake of completeness, I note that at the request of Child T's parents, the Department asked Ms C to arrange for Child T to have an influenza vaccination. Child T saw Dr Price (a colleague of Dr Thorpe) for this purpose on 30 May 2019 and received a booster shot, which is normal practice for children, on 4 July 2019.[33]

GP Appointments[34,35,36,37,38,39]

51. The evidence makes it clear that Ms C took Child T to appointments with several general practitioners and one occasion to RGH. In summary, the details of those consultations are as follows:

a. 10 September 2018 - RGH
Reason: vomiting and diarrhoea.
Outcome: given anti-emetic medication along with advice rehydration. Advised to see a GP and obtain stool sample if symptoms persisted.

b. 12 September 2018 - Rockingham Medical Centre (Dr Coward)
Reason: vomiting and diarrhoea. Child T was noted to be well-hydrated.
Outcome: gastroenteritis, stool sample showed no pathogens. Symptoms had settled by about 24 September 2018.

c. 10 October 2018 - Bayside Medical Centre (Dr Thorpe)
Reason: cough.
Outcome: chest clear. Noted 12-month vaccinations not received.

d. 11 October 2018 - Bayside Medical Centre (Dr Thorpe)
Reason: check-up re cough which was worse.
Outcome: chest infection, prescribed antibiotics.

e. 17 October 2018 - Bayside Medical Centre (Dr Thorpe)
Reason: check-up re cough - which had almost gone.
Outcome: chest clear. Advised to complete course of antibiotics.

[33] ts 04.02.21 (Thorpe), pp43-44
[34] Exhibit 1, Tab 16, Rockingham General Hospital - Emergency Department Notes (10.09.18)
[35] Exhibit 1, Tab 17, Report - Dr I Onwuegbuna (24.10.19)
[36] Exhibit 1, Tab 18, Report - Dr M Mushrafi (18.06.19)
[37] Exhibit 1, Tab 19, Report - Dr M Monroe (23.07.19)
[38] Exhibit 1, Tab 20, Report - Dr V Thorpe (30.07.19)
[39] Exhibit 1, Tab 6, Statement - Ms C, paras 13-33

f. 11 December 2018 - Bayside Medical Centre (Dr Thorpe)
Reason: loose smelly. 12-month vaccinations given.
Outcome: vaccinations completed, pathology test form given re stools.

g. 8 January 2019 - Bayside Medical Centre (Dr Thorpe)
Reason: check-up re bowels, which had settled. Stool sample not sent.
Outcome: 18-month vaccinations given.

h. 17 January 2019 - Return from contact visit[40]
Reason: red dots noted on back of neck, possible heat rash.
Outcome: Ms C advised Department, agreed to monitor.

i. 1 February 2019 - Advice to Department from Ms C[41]
Reason: two nose bleeds the previous night, cause unclear.
Outcome: no follow-up treatment required.

j. 26 February 2019 - Child Health Nurse check[42]
Reason: routine check by child health nurse.
Outcome: no abnormalities noted.

k. 16 April 2019 - Day care staff observation[43]
Reason: nose bleed.
Outcome: no apparent cause, query if Child T stuck his finger up his nose.

l. 21 May 2019 - Child Health Nurse observation[44]
Reason: Child T vomited after contact visit.
Outcome: concerns Child T was given caffeine. Nurse queried if there was a family history of bowel disorders that warranted investigation.

n. 30 May 2019 - Bayside Medical Centre (Dr Thorpe)
Reason: influenza vaccination.
Outcome: vaccination given.

o. 9 June 2019 - Rockingham Medical Centre (Dr Onwuegbuna)
Reason: cough, diarrhoea and runny nose.
Outcome: upper respiratory tract infection, prescribed antibiotics. Well hydrated, no fever, jaundice or anaemia.

[40] Exhibit 1, Tab 23, Report - Ms J Tang, Department of Communities (27.11.20), p12
[41] Exhibit 1, Tab 23, Report - Ms J Tang, Department of Communities (27.11.20), p12
[42] Exhibit 1, Tab 26, Health Improvement Plan (26.02.19)
[43] Exhibit 1, Tab 23, Report - Ms J Tang, Department of Communities (27.11.20), p14
[44] Exhibit 1, Tab 23, Report - Ms J Tang, Department of Communities (27.11.20), p14

p. 17 June 2019 - Core Medical Centre (Dr Monroe)
Reason: sent home from day care with cough and fever.
Outcome: on examination chest clear, fever, runny nose and cough noted. Swab taken for influenza. Return if symptoms worsen.

q. 18 June 2019 - Get Better After hours GP (Dr Mushrafi)
Reason: recurrent nose bleeds.
Outcome: chest clear, nose had stopped bleeding. See GP if symptoms persist.

r. 19 June 2019 – Core Medical Centre (Dr Monroe)
Reason: follow-up appointment, swab positive for influenza.
Outcome: much improved, no longer coughing. Eating and drinking and temperature had settled. Antibiotic ointment prescribed for nasal sores caused by runny nose, or nose picking.

s. 4 July 2019 - Bayside Medical Centre (Dr Price)
Reason: second influenza vaccination.
Outcome: slight temperature (37.2˚C), but considered well enough for vaccination.

Comments on medical care

52. On the basis of the available evidence, I am satisfied that Child T's medical needs were appropriately addressed during the time that he was in the Department's care. It is clear that Ms C was proactive in terms of taking Child T to see a doctor when this was warranted.

53. According to Dr Thorpe, the delay in Child T receiving all of his recommended 12-month vaccinations did not play any role in Child T's death.[45].

[45] ts 04.02.21 (Thorpe), p44-45

EVENTS LEADING TO CHILD T's DEATH[46,47]

54. Mr Stops advised the Court that AB had said that on 11 July 2019, she contacted a caseworker following a contact visit with Child T at CD's mother's home. AB says she noticed that Child T was cold and pale, had a rattle in his chest and seemed "*quite drained*". Although there is no record of this visit in departmental records, Mr Geddes said this sometimes happened when a visit was arranged by the parties rather than the Department. AB also says she left a message for Child T's caseworker, but there is no record of this contact either.[48]

55. On 12 July 2019, Ms C dropped Child T and his sibling off at their day care centre. Child T was reported to be "*fine and wasn't showing any signs of a cough or the flu*". Day care centre staff did not contact Ms C during the day with any concerns about Child T, but when Ms C arrived to collect him at about 5.30 pm, a staff member told her that Child T had just started coughing "*really badly*". Ms C told the staff member that Child T's cough did come and go, especially when it was cold and it was worse in the late afternoon.[49,50]

56. When Ms C got home with the children she decided not to bath them because of Child T's cold. Instead, she got them into their pyjamas and dressing gowns and as a treat, she bought them fast food for dinner. Child T ate some, but not all of his dinner and seemed tired. He was also coughing "*quite a bit*".[51]

57. Child T said he wanted to go to bed and because he was still coughing, Ms C gave him a standard dose of Children's Panadol (i.e.: 5 mls) by way of a syringe into his mouth. Just after 7.30 pm, Ms C placed Child T in his cot. Although she put him on his back, he rolled onto his stomach, which was his preferred sleeping position. He was dressed in long poly/cotton pants, a t-shirt and a long sleeved pyjama top.[52]

---

[46] Exhibit 1, Tab 8, Report - Coronial Investigation Squad, pp3-4
[47] Exhibit 1, Tab 7, Statement - Mr C, paras 11-23
[48] ts 04.02.21 (Stops), pp54-55 and ts 04.02.21 (Geddes), pp54-55
[49] Exhibit 1, Tab 6, Statement - Ms C, paras 30-32 and ts 04.02.21 (Ms C), p11
[50] Exhibit 1, Tab 12A, Email from Ms K Wholan to Sen. Const. J Robinson (14.02.20)
[51] Exhibit 1, Tab 6, Statement - Ms C, paras 33-34 and ts 04.02.21 (Ms C), pp11-12
[52] Exhibit 1, Tab 6, Statement - Ms C, paras 35-46 and ts 04.02.21 (Ms C), p11-12

58. Child T's bedroom did not have a heater, but was insulated and there were block-out blinds on the windows. When Ms C placed Child T in his cot, she covered him with three blankets, one of which was thick and woolly.[53]

59. After placing Child T into his cot with his teddy, Ms C told him she loved him and wished him goodnight. At around 8.30 pm, she thought she heard Child T coughing so she listened by his door but didn't hear any sounds. After locking up the house, Ms C went to bed sometime between 11.00 pm on 12 July 2018 and 12.00 am on 13 July 2019.[54]

60. Ms C says she woke two or three times during the night. On each occasion, she thought she had heard one of the children and she got out of bed and popped her head into their bedroom. It was dark and she looked inside their room without turning on the light. Although she could not see into Child T's cot, Ms C noted that he was not standing up, which is what he usually did if he was awake.[55]

61. Ms C woke up the next morning at about 7.00 am and "*stuck her head around the door*" to check on Child T and his sibling. Although she did not physically check on them, she says they were both still asleep. Ms C had a shower and a cigarette before attending to some household chores. Her former husband arrived at about 11.00 am and they went outside for a cigarette. Ms C joked with him that the children were still asleep.[56,57]

62. Ms C says she wanted to let the children sleep in. It was school holidays and unlike term-time weekends, her son was not playing football that morning and there were no plans for the day. Ms C and her former husband were about to watch the football on television when Ms C heard Child T's sibling say something and her former husband went to check on him.[58,59]

[53] Exhibit 1, Tab 6, Statement - Ms C, paras 47-48 and ts 04.02.21 (Ms C), p13
[54] Exhibit 1, Tab 6, Statement - Ms C, paras 49-55 and ts 04.02.21 (Ms C), pp13-14
[55] Exhibit 1, Tab 6, Statement - Ms C, paras 56-60 and ts 04.02.21 (Ms C), pp15-16
[56] Exhibit 1, Tab 6, Statement - Ms C, paras 61-68 and ts 04.02.21 (Ms C), p16
[57] Exhibit 1, Tab 7, Statement – Mr C, paras 10-13
[58] Exhibit 1, Tab 6, Statement - Ms C, paras 61-72 and ts 04.02.21 (Ms C), pp16-18
[59] Exhibit 1, Tab 7, Statement – Mr C, paras 14

63. When he got to the children's bedroom, Ms C's former husband opened the security gate and Child T's sibling came into the lounge. He followed the child into the lounge and he and Ms C chatted for a time.[60,61]

64. Sometime before about midday, Ms C went to wake Child T so that he would sleep that night. She let down the side of his cot and noted that he was lying on his stomach with his arms outstretched. As Ms C placed her hand on Child T's back to wake him slowly so as not to frighten him, she realised he was cold to the touch.[62]

65. As Ms C turned him over, she realised Child T was stiff, his face was white and his lips were a bluish-purple colour. It was clear that Child C was dead and Ms C went to tell her former husband what had happened. He came into the bedroom and checked on Child T and as he called emergency assistance, Ms C rang the Department's Crisis Care line. Records show that the call to Crisis Care was made at 11.58 am, whilst the call to emergency services was logged at just after 12.00 pm.[63,64,65]

66. Police and ambulance officers arrived on the scene and it was confirmed that Child T had been deceased for some time. He was formally identified by AB at the State Mortuary on 16 July 2019.[66,67,68]

67. Ms C told police that she had not checked on Child T and his sibling for an extended period because she wanted them to have a sleep in. It was school holidays and the family had no plans that morning and as Child T had not been "*100%*", she thought that a long sleep would be good for him.[69,70] I note that a police investigation concluded that there were no suspicious circumstances in relation to Child T's death.[71,72]

---

[60] Exhibit 1, Tab 6, Statement - Ms C, paras 73-74 and ts 04.02.21 (Ms C), pp17-18
[61] Exhibit 1, Tab 7, Statement – Mr C, paras 14-16
[62] Exhibit 1, Tab 6, Statement - Ms C, paras 75-78 and ts 04.02.21 (Ms C), pp18-19
[63] Exhibit 1, Tab 6, Statement - Ms C, paras 79-86 and ts 04.02.21 (Ms C), pp19-20
[64] Exhibit 1, Tab 7, Statement - Mr C, paras 17-21
[65] Exhibit 1, Tab 15, St John Ambulance patient care record (13.07.19)
[66] Exhibit 1, Tab 15, St John Ambulance patient care record (13.07.19)
[67] Exhibit 1, Tab 2, Life extinct certificate (13.07.19)
[68] Exhibit 1, Tab 3, Identification of deceased person (16.07.19)
[69] Exhibit 1, Tab 12, Statement - Sen. Const. J Robinson, (17.04.20), paras 10-14
[70] Exhibit 1, Tab 10, Memo - Det. FC Const. R Murdoch, Rockingham Detectives Office, (13.07.19)
[71] Exhibit 1, Tab 12, Statement - Sen. Const. J Robinson, (17.04.20), paras 10-14
[72] Exhibit 1, Tab 10, Memo - Det. FC Const. R Murdoch, Rockingham Detectives Office, (13.07.19)

COMMENTS ON CHILD T's CARE

Should the Department have intervened earlier?

68. The Department's decision to take Child T and his sibling into provisional care on 23 August 2018 was clearly appropriate, as were the subsequent proceedings to obtain a care and protection order.

69. However, on the basis of the evidence available to the Department, it is my view that the decision to take Child T and his sibling into care could have been taken earlier, and certainly by early July 2018. By that stage, the Department should have been sufficiently concerned about the impact on Child T and his sibling of the domestic and family violence that AB was being subjected to, as well as CD's ongoing use of illicit drugs.

70. Whilst I accept that the removal of a child from its parents is an action of last resort, in this case, if the Department did not consider apprehension action was warranted in July 2018, then clearly intensive family support should have been provided to AB, and at a much earlier stage.

71. In this case, there were several occasions when significant concerns about Child T's welfare were raised with the Department and where the Department's response was clearly suboptimal. One of these occasions was on 24 July 2018, when the Department received information that CD had made threats to kill AB and the children, was behaving erratically and was apparently under the influence of illicit drugs.

72. Instead of taking immediate action to investigate these serious allegations the Department did not act until 30 July 2018. On that date, instead of a face to face meeting at which the children could have been physically sighted, a caseworker rang AB to check on her situation and AB's assertions about the children's welfare were accepted at face value. As Mr Geddes properly conceded, this was an unacceptable response.

73. Similarly on 15 August 2018, when AB and CD cancelled an appointment with a caseworker to discuss concerns about the children's welfare, no immediate action was taken.

74. The Department's failure to provide more intensive family support to AB at an early stage and to respond in a timely manner when significant concerns about the children's welfare were raised are obviously matters of concern. Mr Geddes accepted that the Department's failure to engage more actively with Child T's parents was a missed opportunity.[73] Nevertheless, I accept that in this case, even if the Department's response had been more comprehensive and/or if Child T and his sibling had been apprehended by the Department at an earlier stage, there is no basis for concluding that the outcome in this case would have been any different.

75. Other than my concern about the intensity and timeliness of the Department's intervention, I am satisfied that the care, supervision and treatment provided to Child T during the time he was in the Department's care, was adequate.

Comments on Ms C's care of Child T

76. The documentary evidence makes it clear that Ms C is a caring and compassionate person and her decision to be a foster career should be applauded. In addition to caring for her own child, Ms C took on the responsibility for looking after not only Child T, but his sibling as well. Both children had health issues when they came into care and Ms C was proactive in seeking medical attention.

77. When Child T and his sibling came into her care, Ms C had already successfully cared for two other foster children and she was clearly aware of the need to take childhood illnesses seriously.

78. During the evening of 12 July 2019, it is clear that Child T was feeling tired and had been coughing from time to time. In that context, it is quite understandable that Ms C should wish that Child T should have a long sleep. During the night of 12 - 13 July 2019, Ms C checked on Child T two or three times after she thought she heard noise coming from his bedroom.

[73] ts 04.02.21 (Geddes), p56

79. It is understandable that she did not turn on Child T's bedroom light when she checked him, but with the benefit of hindsight, and especially given that Child T had been coughing earlier, it is my view that a prudent parent in Ms C's shoes would almost certainly have physically checked the child.

80. I also consider that a prudent parent in Ms C's position would have physically checked Child T on the morning of 13 July 2019, prior to the time when she found him deceased in his cot. The fact that neither Child T nor his sibling had stirred by mid-morning should have prompted Ms C to have physically checked on the chilren to see why they had not woken up.

81. Having said that, I do accept that the children were being given the opportunity for a "*sleep-in*" and I note that Child T's sibling did not wake up until shortly before Child T was discovered.

82. An article in the journal *Australian Family Physician* pointed out that seriously unwell children pose challenges to medical practitoners because:

> The anatomy and physiology of children is different to that of adults, and this can result in differences in the presentation and severity of a range of conditions...Children have a great ability for physiological compensation and some of the early signs of illness may not be obvious. The emphasis should be on detecting and treating the seriously ill child at an early stage to prevent deterioration.[74]

83. Dr Thorpe noted that a child's medical conditon could appear stable for some time before suddenly changing for the worse. This was partly due to a child's different physiology and partly because their immmune system is not fully formed.[75]

[74] Australian Family Physician, Vol. 39, No. 5, May 2010
[75] ts 04.02.21 (Thorpe), pp46-47

84. In this case, there is no evidence that Child T was "*seriously unwell*" when he was last seen on the evening of 12 July 2019. Although he was coughing from time to time, he ate some of his dinner and appeared to settle after being given some Children's Panadol. The fact that his condition deteriorated so rapidly overnight may well have been a manifestation of the physiological compensation referred to above.

85. It is easy to be wise in hindsight and that I do not mean to suggest that had Ms C physically checked on Child T at earlier stage, he would not have died.

86. The time of Child T's death cannot be determined. The only evidence on this point is that by the time Child T was physically checked shortly before 12.00 pm on 13 July 2019, he had been deceased for "*some time*".

CAUSE AND MANNER OF DEATH

Post mortem examination[76,77,78,79,80]

87. A forensic pathologist (Dr Cadden) conducted a post mortem examination of Child T's body on 16 and 19 July 2019. He found no primary pathology, congenital abnormality or trauma that would readily explain the death. Macroscopic examination of Child T's brain showed some swelling, but no other abnormalities.

88. Microbiology testing detected the enterovirus RNA in Child T's small and large intestine and his right lung. The respiratory syncytial virus RNA was found in the left lung and in right and left bronchi, tonsils and trachea, along with enterovirus RNA. The bacterium *Clostridium perfringens*, which can cause diarrhoea, was grown in a blood culture and a middle ear swab contained the bacterium *Moraxella catarrhalis* which can cause upper respiratory tract infections.

89. A review of tissue from Child T's lungs showed inflammatory changes consistent with pneumonia in a setting of a common chest infection (bronchiolitis). Toxicological analysis detected paracetamol in his system, but was negative for common drugs. A urine alcohol level of 0.021% was detected, but Dr Cadden noted that this would have been due to post mortem changes rather than ingestion of alcohol.

Cause and manner of death

90. At the conclusion of the post mortem examination, Dr Cadden expressed the opinion that cause of Child T's death was pneumonia in association with bronchiolitis. I accept and adopt Dr Cadden's opinion as to the cause of death.

91. Having considered the available evidence, I find Child T's death occurred by way of natural causes.

[76] Exhibit 1, Tab 4A, Supplementary post mortem Report
[77] Exhibit 1, Tab 4C, Letter - Dr G Cadden (26.03.20)
[78] Exhibit 1, Tab 4B, Letter - Dr G Cadden (12.05.20)
[79] Exhibit 1, Tab 5, ChemCentre toxicology report
[80] Exhibit 1, Tab 4C, Letter - Dr G Cadden (06.09.19)

CONCLUSION

92. The Department's decision to take Child T and his sibling into care on 23 August 2018 was clearly correct. The evidence establishes that at that time, the children were being exposed to domestic and family violence and that their biological parents were regularly using illicit drugs.

93. In my view the Department should have provided more intensive support to Child T's parents at an earlier stage. However, there is no evidence that had the children been apprehended earlier, the outcome in this case would have been any different.

94. On the basis of the evidence before me, I concluded that the standard of care, supervision and treatment that Child T received whilst he was in the care of the Department was adequate.

MAG Jenkin
Coroner
11 February 2021