**Coroners Act, 1996**

**[Section 26(1)]**

***Western Australia***

# ***RECORD OF INVESTIGATION OF DEATH***

***Ref No:18/14***

*I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of* ***BC*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***20-22 May 2014*** *find the identity of the deceased baby was* ***BC*** *and that death occurred on* ***29 June 2010*** *at* ***Royal Darwin Hospital, Darwin, Northern Territory,*** *as a result of* ***Acute Meningitis*** *in the following circumstances:*

**Counsel Appearing:**

Ms I. Burra-Robinson assisted the Deputy State Coroner
Mr D. Harwood (instructed by State Solicitors Office) appeared on behalf of WA Country Health Service (WACHS) Child and Adolescent Health Service (CAHS) and the Department of Child Protection and Family Support (the Department)

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## SUPPRESSION ORDER

**That no report of the Inquest or part of any proceedings which would identify or tend to identify the deceased be made in this matter and the deceased to be referred to as BC.**

## INTRODUCTION

BC was born on 18 January 2010 at King Edward Memorial Hospital in Perth as an apparently healthy full-term baby boy. His mother returned to the Kimberly with BC and was supported by the Department for Child Protection and Family Support (the Department) in Halls Creek.

On 24 April 2010 BC and his mother were moved to supported accommodation in Wyndham pending transition to a community. BC became unwell and was taken to Wyndham Hospital, transferred to Kununurra Hospital (KH), both Western Australian Country Health Service (WACHS) facilities, before being transferred to Princess Margaret Hospital (PMH) in Perth.

BC was discharged three weeks later on antibiotics. He had improved but the cause of his illness remained undiagnosed. He was due for follow up review on 11 June 2010 at KH by a visiting paediatrician, specifically to assess any remaining signs and symptoms which may clarify a clinical diagnosis for his illness. A discharge letter was sent

from PMH to KH as the referring hospital.

On Thursday 10 June 2010 BC's mother, (Wendy) asked the Department whether she could take BC to her family's community at Crocodile Hole, out of Warmun. Approval was given for a weekend visit only, and she was expected back in Wyndham on 14 June 2010. There appeared to be no knowledge of the appointment for BC at KH with a visiting paediatrician.

Wendy did not return to Wyndham on 14 June 2010.

On Thursday 17 June 2010 a disability support worker (Dennis Thompson) visited Crocodile Hole and observed BC, whom he believed to be unwell. He reported the matter to a nurse at Warmun Health Clinic (WHC, part of WACHS). The nurse made various enquiries with the Department, WACHS facilities and PMH but was only provided with the referral for BC from Wyndham Hospital to KH, before his transfer to PMH. On the information with which she was provided she did not believe the matter to be an emergency and asked that BC's mother be asked to bring BC to WHC for review. BC's mother declined to bring BC to the clinic.

Ongoing telephone calls did not raise a level of concern for BC without knowledge of the PMH discharge letter and missed appointment at KH.

By 21 June 2010 Dennis Thompson was frustrated enough by the lack of response to his concern for BC he called the Department's after hours Crisis Care Service and reported his concerns.

On 22 June 2010 staff from the Department in Halls Creek drove to Crocodile Hole and found BC unresponsive. BC was driven to WHC and resuscitation efforts instituted. BC was transferred by Royal Flying Doctor Service (RFDS) from WHC to Royal Darwin Hospital (RDH). BC did not recover and died on 29 June 2010.

BC was five months and eleven days of age.

BC was never the subject of an application for an order for care and protection. This was a discretionary inquest to try and determine exactly what happened and whether any measures may be implemented to minimise the likelihood of a death arising from a similar set of circumstances.

## BACKGROUND

BC had three living siblings at the time of his birth. They were all in the care of the Department, in different situations, due to care and protection orders in place as a result of their early neglect, and their mother's itinerant lifestyle, which included significant intoxication and domestic violence issues.

The Department was involved with the family as a whole and when they became aware of the fact Wendy was again pregnant, they became involved in pre-birth planning with Wendy in the expectation BC would be taken into the care of the Department following a protection order after his birth.

Until the involvement of the Department, BC's mother had not received antenatal care. She was involved in incidents requiring input from staff at Ord Valley Aboriginal Health Service (OVAHS), WHC and KH arising out of intoxication. Health practitioners at those facilities raised concerns with the Department steps should be taken to protect the health of her unborn child. BC's mother also contacted the Department during this period seeking guidance as to how she could regain care of all her children, and to advise that she was now pregnant again. This provided ample opportunity for the Department to become involved in BC's pre-birth planning. At the time Wendy was subject to an intensive supervision order (ISO) for 12 months so it was a good opportunity to put a plan in place for the birth of BC.

On 2 December 2009 the Department put in place a recommended plan for action and an outcome report. That report recommended:

- Parent support (Best Beginnings) to continue working with Wendy on a regular basis;

- Child Health Nurse to continue with regular visits with both Wendy and BC when born;

- Kinway counselling to continue visiting Wendy on a regular basis when in Halls Creek;

- The Department to monitor Wendy and her progress with the services;

- If successful, plans will be made for Wendy and baby to transition into independent living arrangements with continued supports in place.

The team leader of the team involved with the care of the family as a whole, Barbara Binks, advised the district director they were still deciding whether BC would be able to stay in his mother's care once her progress had been assessed. Her Case Manager, Kylie Birchall-Hunt, was in continued discussions and guidance with Wendy. By the end of December 2009 a decision had been made that BC would be placed in the care of the CEO of the Department once born.

There was ongoing liaison with Crisis Care, and once Wendy was in KEMH, their social services welfare unit. The Department was aware there needed to be a complex planning meeting with all social services and KEMH. Thus, at the time of BC's birth the plan on behalf of the Department was to continue to assess an outcome, but the expectation was BC would be place in the care of the CEO of the Department.[1]

[1] t 20.05.14, p9-10

BC was then born on 18 January 2010. He was healthy.

Following his birth, discussions were held between the various services involved for a hospital to hospital transfer for Wendy and BC, pending Wendy complying with a transfer. In the event she declined transfer and wished for discharge, the Department was concerned about the process for taking BC into care. They needed to plan for a placement in the event it was necessary to take him into care. Discussions were had with Wendy's extended family about options for placement for BC in the event he was taken into care. A preliminary plan was in place for BC to be placed in the care of Wendy's aunty, along with two of her other children.

Wendy agreed to transfer and on 23 January 2010 she and BC were transferred from KEMH to KH who agreed not to discharge Wendy pending a meeting between various parties as to BC's future. Crisis Care was made aware of the plan in the event Wendy discharged herself.

At around the same time Wendy made it clear she was prepared to accept guidance from the Department in the care of BC and that she did not wish to return to an environment which would place her in danger of intoxication. She was also hopeful she would reunite with BC's father.

On 25 January 2010 there was a meeting between representatives of the Department, Wendy and a legal representative, and various other support agencies to discuss the future for both Wendy, BC and plans for family reunification.

The Department file indicates the KEMH discharge notes were provided to the Department, and filed on BC's file, despite the understanding BC was not in the care of the CEO of the Department, although his family was supported by the Department.

Following that meeting the Department looked at options of homes for Wendy and BC where the Department would be able to support them, despite BC not being in their care. The preference was for an address in Halls Creek close to Departmental presence. Eventually the independent living unit attached to the DCP Hostel in Halls Creek was deemed an appropriate option for Wendy and BC. Wendy expressed a wish to not drink alcohol, and to look after BC properly.

KH mid-wives advised the Department Wendy and BC were doing well and Wendy was responding appropriately to BC. They had no medical concerns for BC who was putting on weight and appeared to be developing normally.

It is in this context the Department made the decision to

support the family, rather than have BC in their care. BC could have remained with his mother while still being in care of the Department but it was hoped these plans would encourage Wendy to parent properly and provide an opportunity to remove her three other children from care. A potential to provide them with a family unit and so break a cycle of care dependency was a hoped for outcome.

In this way Ms Birchall-Hunt became the family case worker, and Ms Binks the team leader responsible for the family. Both officers were located at the Department's Halls Creek Office.

On 27 January 2010 Ms Binks transported Wendy and BC from KH to Halls Creek to reside in the Halls Creek Independent Living Unit. Referrals were also put in place to assist Wendy with parental support and alcohol counseling, while the local child health nurse was to review BC and follow his development.

In early February 2010 Wendy became less enthusiastic about the prospect of remaining in Halls Creek. There were concerns raised she may be suffering postnatal depression. Through February it is obvious Ms Binks spent a considerable amount of time, in consultation with Ms Birchall-Hunt, in providing Wendy with a significant amount of input and support for her parenting role.[2]

[2] t 20.05.14, p12

BC's paediatric review for 20 March 2010 noted no health concerns with his progress. Discussions were then instituted as to the appropriate place for Wendy to stay with BC to enable her to transition to her community, but still remain guided by the Department. Options of a location in Wyndham were discussed. In March, through April of 2010, plans were made for Wendy and BC to be relocated to the Department's safe house in Wyndham, with input from the Department and community health services.

On 25 April 2010 Wendy and BC were relocated to Wyndham. The plan was they reside there for eight weeks while further progress was made towards community living, with family support, for Wendy and BC. There was no difficulty with information sharing between the Department and community health services despite the fact BC was not legally in the care of the Department.[3]

Plans for Wendy and BC to reside with a family member in Guda Guda Community were also discussed for future reference.[4] The indications at that time were Wendy was caring well for BC and the Department was hopeful her continued care of him would be successful.

On 6 May 2010 the Wyndham departmental office advised Halls Creek departmental office BC had been taken to

[3] t 20.05.14, p13, p16, p39
[4] t 20.05.14, p63

Wyndham Hospital with a temperature, and then transferred to KH. KH also advised the Kununurra departmental office that Wendy was caring for BC and that he had been admitted with suspected septicemia. The Halls Creek office was then told BC needed to be transferred to PMH. Halls Creek contacted PMH and advised them BC and his mother were being supported by the Department and liaison was instituted between PMH social workers and Halls Creek departmental office.

## PRINCESS MARGARET HOSPITAL (PMH)

BC was admitted to PMH on 7 May 2010 with his mother. He had a febrile illness with multiple splenic lesions/abscess confirmed by ultrasound.[5] BC was treated with broad spectrum intravenous (IV) antibiotics which were rationalised during his admission. He developed haemolytic anemia with a raised reticulocyte count, thought to be secondary to his abscesses.

BC's illness resolved and Wendy was very anxious to leave hospital. A cause for BC's splenic abscesses was not diagnosed and splenomegaly had not resolved by discharge. Referrals to the visiting paediatric consultant at KH were made to ensure the issue of BC's enlarged spleen was investigated. An appointment was made for 11 June 2010 to facilitate examination of BC once his course of antibiotics

[5] Ex 1, Tab 5

had been completed, and to ensure his four monthly immunisations. Halls Creek departmental office was advised of BC's imminent discharge.

BC was discharged from PMH on 25 May 2010. He and Wendy returned to the Wyndham safe house.

A discharge letter was sent to KH advising of the discharge and the appointment referral. The discharge letter indicated the source of BC's illness was undiagnosed, as was the reason for his enlarged spleen. It made it clear the appointment for 11 June 2010 was an important part of BC's future appropriate healthcare.[6] WHC was not provided with a copy of the discharge letter although it was addressed to them.

Despite PMH's knowledge of the Department's Halls Creek office involvement with BC, a copy of the discharge letter was not sent to that office, nor did KH place the discharge letter on their file for BC or his mother, rather it went straight to the visiting paediatrician's appointments list.

The fact the Halls Creek departmental office had advised PMH of their support for Wendy and BC does not appear to have triggered any response surrounding their discharge other than practical arrangements surrounding their transfer back to Wyndham.

[6] Ex 2, Tab 30

## RETURN TO WYNDHAM

Contact was made with Wendy on her return to Wyndham by the family case manager, in Halls Creek, by telephone. Wendy advised BC seemed better but she did not appear to have any information about ongoing issues or what had been the problem. Her capacity to understand may have been an issue.[7] The Department did not appreciate there were any ongoing issues which needed their input, they were not advised of any, nor did they inquire. The assumption was BC was well.

On 3 June 2010 the Department received information from Wyndham safe house it would be closing towards the end of June and new arrangements would need to be made for Wendy and BC's ongoing accommodation and support. Safe House staff believed Wendy wished to go to Crocodile Hole, which is where her father was located, out of Warmun. The Department indicated they would provide a plan and consideration was given to the Guda Guda Community option, out of Wyndham, where there was support for Wendy and BC from a responsible family member.[8]

On 10 June 2010 Wendy rang Halls Creek office and asked if she could travel to Crocodile Hole the next day to be with her father. Both Ms Birchall-Hunt and Ms Binks were at

[7] t 20.05.14, p34, p38
[8] t 20.05.14, p63-4

Halls Creek at the time and discussed between them whether Wendy should be allowed to go to Crocodile Hole. Wendy advised she intended to stay with her sister in a house and jointly look after the children. Power was about to be provided to the community and it seemed to be a good opportunity for Wendy to transit back to community living in stages to see how she progressed and worked with the Department for ongoing care of BC.[9]

It was decided Wendy should be allowed to go to Crocodile Hole for the weekend. The understanding was she was to return to Wyndham on 14 June 2010 and from there consideration would be given to her future accommodation in preparation for transition to a community.

There is no indication anyone in Wyndham or Halls Creek departmental office were aware of the paediatric appointment for 11 June 2010. Evidence given in court indicated had anyone understood there was an appointment permission would not have been provided for Wendy to travel to Crocodile Hole and arrangements would have been made to ensure that BC attended the paediatric review in KH.[10]

[9] t 20.05.14, p19
[10] t 20.05.14, p58

## PAEDIATRIC REVIEW

The appointment for BC on 11 June 2010 with KH visiting paediatrician was not attended, and the appointment form appears to imply one of the Kununurra departmental officers had been advised of the pending appointment.[11] There is no other annotation on the KH file to support when that was done and the form recording his non-attendance for 11 June 2010 appears to be signed on 24 June 2010, after BC's transfer to Royal Darwin Hospital. The form gives no indication of a request for follow-up to enquire as to why he had not attended the appointment.

There is evidence a fax had been sent to WHC by a child health nurse in Wyndham when Wendy and BC were at Crocodile Hole (15 June 2010) but there is nothing to support whether that occurred. There was no mention of his need for review, only the fact he needed immunisation. WHC has no records due to flooding[12] but the people nominated in the fax have no recollection of the fax or the events to which it refers.[13]

## CROCODILE HOLE

Crocodile Hole is a small community comprising five houses about 30 km out of Warmun Community, only used in the

[11] Ex 2, Tab 30
[12] t 21.05.14, p102
[13] Submissions on behalf of WACHS dated 25.09.14 paras 46-48, attach 3.

dry season when the roads are not subject to flooding.[14] It is serviced by facilities in Warmun Community, including WHC. It is 230 kms from Halls Creek. It was the family community of BC's mother, Wendy, and her father and uncle resided there. One of Wendy's sisters had died in late April and she had not been to Crocodile Hole to be with her family since that time.

Wendy's niece, Delena Henry, also resided in the Crocodile Hole Community and assisted Wendy in providing care for BC in the time they were at Crocodile Hole. She stated that for approximately a week prior to BC being removed from the community he was a little sick and always hot.[15] She helped Wendy give the deceased cold showers to keep him cool and noted he was crying most of the time.

Ms Henry noted BC as being very sick in the three days before he was taken from Crocodile Hole by the Department. She stated it was difficult for Wendy to seek medical assistance as nobody had a driver's licence within the community and Wendy was frequently drunk. Ms Henry said Wendy would look after BC until she consumed alcohol, at which time Ms Henry would take over his care.

Wendy's father, and the maternal grandfather of BC, made a statement he thought Wendy was a good mother because she fed and changed the baby before his death. He agreed

[14] t 21.05.14, p94
[15] Ex 1, Tab 22

Wendy drank alcohol but in his view it was not excessive and was generally only on the weekends. From his perspective BC cried a lot during the night.[16]

Wendy's uncle had not observed BC to be unhealthy when he observed him a day or two before the Department removed him. He confirmed Wendy as being a big drinker prior to having BC, but thought she had stopped consuming alcohol once he was born. He believed she had done her best to care for the baby and that on the times he observed BC he appeared to be well fed and changed.[17]

The manager of Disability House in Warmun Community, Dennis Thompson, would make frequent visits to Crocodile Hole to take care of BC's grandfather. He had known Wendy, both before and after, BC's birth. Mr Thompson visited Crocodile Hole when there were residents present, every Thursday, and frequently visited one to two other times during the week.

Mr Thompson had a clear recollection of his involvement with BC and Wendy at the time of BC's removal from Crocodile Hole, but his memory of events in the two weeks preceding needed some prompting, even when reminded of conversations he had apparently had with both the WHC nurses and Halls Creek departmental staff. More contemporaneous recordings of those conversations than

[16] Ex 1, Tab 21
[17] Ex 1, Tab 23

his evidence given in court, reflected the fact Mr Thompson had first become concerned about BC's presentation on either 16 or 17 June 2010.[18]

This was two to three days after Wendy was supposed to have returned to Wyndham in accordance with her agreement with the family case manager, Ms Birchall-Hunt. Departmental staff at Halls Creek rang Wendy's mobile on Monday the 14th but it appeared to be switched off. Other witnesses confirmed mobile coverage in and around the area could be patchy.

Ms Birchall-Hunt again tried to ring Wendy on Tuesday 15th and Wednesday the 16th but was not able to contact Wendy. Ms Birchall-Hunt and the child care worker, Priscilla Williams, had a discussion about the inability to contact Wendy and agreed it was possible she was travelling back to Wyndham or was having difficulty getting back to Wyndham.[19] They decided they would not raise an alarm about her failure to return just yet. They were also unable to raise the Crocodile Hole public pay phone.

In consultation with the team leader, Ms Binks, it was agreed they would wait for Wendy to contact them. This was due to their very positive impression of Wendy's genuine attempts to care for BC and the reports they had received from workers at the Wyndham safe house she was

[18] t 20.05.14, p22, 23
[19] t 20.05.14, p21

caring for her baby well.[20] They were still unaware of the missed appointment for 11 June 2010 and the fact the medical practitioners in Perth believed he was suffering from an undiagnosed condition which needed competent review.

The following outline is the best factual scenario possible from the evidence given at the inquest. Each of the participants in the events had a slightly different recall by the time of giving evidence in court and I have largely held to the facts as recorded at the time, in conjunction with people's memories as to the sequence of events.

It is apparent Mr Thompson visited the community to care for Wendy's uncle on either 16 or 17 June 2010 and spoke with Wendy and her father about BC. Mr Thompson did not initially recall this earlier conversation, however, in court agreed he did remember something about an insect bite.[21]

There was some concern about BC on either the Wednesday or Thursday and when Mr Thompson returned to Warmun, he went to the clinic and advised one of the nurses, Emma Tuena, of the fact Wendy was at Crocodile Hole and was there with BC. Nurse Tuena had previous knowledge of Wendy due to events during her pregnancy. Mr Thompson also confirmed in court on the occasions he had been to Crocodile Hole and observed Wendy he believed her to be

[20] t 20.05.14, p22
[21] t 20.05.14, p47

intoxicated, both pre BC's birth and recently.

Nurse Tuena was surprised she had not been notified by the Department Wendy and BC were at Crocodile Hole. This would tend to confirm she had no knowledge of a fax from Wyndham child health nurses dated 15 June 2010. Consequently, she telephoned the Halls Creek office and asked if they were working with Wendy and knew she and BC were at Crocodile Hole. Ms Birchall–Hunt agreed the Department was working with Wendy and she had permission to visit the community.

Nurse Tuena then passed on the information that Mr Thompson thought BC was unwell. Ms Birchall-Hunt explained BC had been sick and had been sent to PMH approximately four weeks earlier, but had been discharged back to KH. Nurse Tuena cannot recall the exact sequence of events and was not sure who informed her about BC's stay at PMH but agrees she was alerted to that fact. As a consequence she attempted to obtain further information about his hospital stay. The Department stated they had little information and had not heard anything about his discharge or any follow ups.

Nurse Tuena then attempted to obtain discharge information about BC but was unsuccessful and as a result believes she rang PMH directly.[22] PMH would not provide

[22] t 21.05.14, p99

the WHC Nurse with the discharge summary for BC on the grounds it was confidential information and there needed to be written permission from BC's guardian. From this Nurse Tuena assumed there was not a problem with BC's discharge, and on re-ringing Wyndham Hospital, as the originating hospital, was provided with the transfer information from Wyndham Hospital to KH prior to BC's stay in PMH. From those documents Nurse Tuena believed BC had been treated and that the current situation was not related to his earlier hospital admission and not an emergency. She had no information with which to make a decision BC needed to be visited at Crocodile Hole on the policies and protocols in place at that time.[23]

In evidence, Nurse Tuena explained that in the event of clinic staff needing to visit a patient away from the clinic it necessitated at least two staff members, or a police escort. Those circumstances may well cause the clinic to close which would only be done in a known emergency. This was in accordance with perfectly acceptable and appropriate guidelines to staff.[24]

Nurse Tuena then advised Mr Thompson to offer Wendy and BC a trip back to Warmun, when he next visited Crocodile Hole, to bring the baby to the clinic.

On his next visit to Crocodile Hole Mr Thompson again saw

[23] t 22.05.14, p144
[24] t 21.05.14, p89

BC and on this occasion was concerned the baby was unwell, but Wendy declined the offer of a lift to the WHC on the grounds she would not be able to return to Crocodile Hole and did not want to be abandoned in Warmun.

Mr Thompson was very concerned on this occasion and frustrated the Department had not visited Crocodile Hole as the result of his earlier communication with WHC.[25] He did not understand WHC had attempted to follow up the situation with BC, but been unsuccessful in obtaining current and relevant information from the health facilities.

Mr Thompson then rang the Department's Crisis Care Unit on 21 June 2010 and spoke with them about Wendy and BC. He reported he did not know the cause of BC's un-wellness but that he was concerned for BC's wellbeing and that his mother was frequently intoxicated. He said he had offered Wendy transport but she declined transport to the clinic. He confirmed that on this occasion Wendy was not affected by alcohol and the baby was clearly unwell.[26]

As a result of the call to Crisis Care information was left with the Department's Halls Creek office to check with Ms Birchall-Hunt about the situation with Wendy and BC. Ms Birchall-Hunt was not present in Halls Creek at that time, however, the team leader received the call. Ms Binks attempted to follow up the information but was advised

[25] t 20.05.14, p48
[26] t 20.05.14, p47

WHC had not seen the baby and had received no information through their inquiries to indicate an ongoing concern with any of the health facilities about his situation.

Ms Binks then decided it was necessary to close the Halls Creek office and travel the 230 km to Crocodile Hole to investigate the situation with Wendy and BC in person.[27] Ms Binks advised her district director they would bring BC back regardless of Wendy's attitude. Ms Binks considered Wendy would not be able to keep BC at Crocodile Hole as there were no appropriate services to take care of him in the event Wendy became vulnerable to drinking when at the community.

On Ms Binks and the child care worker, Ms Williams, arriving at Crocodile Hole at approximately mid-day on 22 June 2010 they found Wendy, sober, and she advised them BC had been crying a lot but was now sleeping. The two departmental workers were impressed with the environs of the community and found the room in which BC was sleeping was well ordered, and BC appeared to be well cared for. He was, however, floppy and unresponsive. Ms Binks was extremely concerned as to his presentation.[28]

Ms Williams was not able to rouse BC and he did not respond to being unwrapped and handled. He appeared to have a high temperature.

[27] t 20.05.14, p30
[28] t 20.05.14, p31-32

Wendy was told BC was sick and had to be taken to the doctor immediately, regardless of whatever she chose to do. Wendy wished to go with her baby and was told to pack all her personal belongings and those of BC because she would not be returning to Crocodile Hole with the baby.

As the group left Crocodile Hole telephone coverage was obtained and they rang WHC to advise BC was being brought in and was in a concerning condition.

## WARMUN HEALTH CLINIC (WHC)

There were three nurses on duty in WHC when BC arrived at approximately two o'clock. The nurses assessed BC as being extremely sick. He was pale in colour and had to be connected to the monitors in the resuscitation room. All three nurses present assisted in his resuscitation.

BC's oxygen saturation was 65%, his heart rate was 112, although he was of normal weight and development. The nurses could see no obvious source of his illness other than a small bruise on his right ankle. His respiratory effort was slightly abnormal at 52 bpm, with the use of accessory muscles.[29] The nurses were concerned he had fixed pin point and unresponsive pupils with dry eyes. They inserted a nasogastric tube and commenced oxygen therapy and his

[29] Ex 1, Tab 13

levels improved.

Nurse Tuena contacted the on call doctor at KH and they were referred to the Royal Flying Doctor Service (RFDS) as it was obviously an emergency. The nurse then dealt with Dr Britton from the RFDS and arrangements were made for transfer. Meanwhile Dr Britton instructed the nurses to insert an intraosseous cannula and commence fluid replacement. BC was also provided with antibiotics, Naloxone in case there was a substance problem and Diazepam as a calmant.

BC's condition started to deteriorate, his pulse rate dropped, his respiratory rate was 60, and then dropped to 20 bpm, and he became mottled. The nurses provided him with an air viva and supported his breathing for half an hour at which time he became able to breathe unassisted until RFDS arrived.

RFDS Paediatrician, Dr Neilson on 22 June 2010, intubated BC and he was transferred to the plane at 5pm. The flight left Warmun for Darwin at 5:20pm. The departmental workers returned to Halls Creek and medical care was transferred to the Royal Darwin Hospital. Wendy was with BC.

## ROYAL DARWIN HOSPITAL (RDH)

Specialist Paediatrician, Dr Paul Bauert, from Royal Darwin Hospital, attended Perth for the purposes of the inquest. Dr Bauert was the consultant paediatrician caring for BC in Darwin on his transfer from Warmun. He noted that BC was intubated and ventilated on arrival, and admitted directly to RDH Intensive Care Unit. BC's neurological status on arrival was flaccid with pin point pupils.

Dr Bauert stated BC arrived at RDH without a discharge summary from PMH, which he thought was a little surprising.[30] He indicated it was some 24hrs before RDH were provided with a copy of BC's discharge information. It was obvious from that information BC had an enlarged spleen and that he had a period of infection, with abscesses on his spleen in May, and had been discharged from PMH on antibiotics pending further review of the cause for his enlarged spleen.

Dr Bauert noted that during BC's admission to RDH he remained unresponsive and the only neurological change observable was that his right pupil became fixed and dilated. He was treated with IV meropenem and acyclovir while multiple investigations were performed. He was diagnosed with *Streptococcus pneumoniae* and his MRI brain scan was profoundly abnormal with areas of infarction, and

[30] t 21.05.14, p69, 70 & 83

the encapsulated bacterial infection being the basis for his acute meningitis. His abdominal CT showed a mass thought to represent an infarcted spleen.

There was no improvement in BC's neurological status over a week and discussions were implemented with Wendy and the child protection services.[31] Discussion with the Department indicated it was unlikely BC would recover and support was put in place for Wendy, by the transportation of supportive family members to Darwin.

RDH had discussed BC's presentation with his treating specialists at PMH and it was considered the unusual appearance of his spleen on ultrasound at PMH during May represented infarcts secondary to a congenital wandering spleen. Dr Bauert explained this was a result of a loose ligament attaching the spleen to the abdominal wall and was a very rare condition.[32] The specialists believed it left BC functionally asplenic and particularly susceptible to torsion (twisting) and pneumococcal sepsis. In addition BC had not received his four monthly immunisations on 11 June 2010, further exposing his vulnerability to infection.

In evidence Dr Bauert stated the missed appointment of 11 June 2010 was critical to BC's proper care in that he believed a paediatrician would have understood the still enlarged spleen was as a result of something other than

[31] Ex 1, Tab 18
[32] t 21.05.14, p71

infection and may well represent splenic torsion. This would indicate the potential for infarction of the spleen and therefore loss of its function in BC's immune ability, affecting both his susceptibility to pneumococcal type infections and the ability of BC's blood to cleanse itself. This was exacerbated by the lack of immunisation on the same date.[33]

In addition, Dr Bauert stated it was possible, had BC attended WHC earlier and the nurses consulted with a doctor about his un-wellness and distended abdomen, there could have been earlier appreciation of BC's un-wellness which would have prompted his presentation at a tertiary facility able to deal with his condition with a significantly improved outcome.[34]

By the time BC reached RDH he was beyond help despite aggressive treatment.

Once support was in place for Wendy the situation was explained and BC's life support was withdrawn.

BC died on 29 June 2010.

[33] t 21.05.14, p71-74
[34] t 21.05.14, p82

## POST MORTEM REPORT

Dr Terrence Sinton, Director of Forensic Pathology at Royal Darwin Hospital, Northern Territory, performed the autopsy of BC on 1 July 2010.

Dr Sinton recorded BC had been diagnosed with bacterial meningitis but died despite treatment after approximately a week in RDH. At autopsy he found meningitis consistent with acute infection.

There was an abnormal twisting of the spleen in the left side of the abdominal cavity (splenic torsion), which had resulted in complete infarction of the spleen. Dr Sinton considered it likely that would have caused BC great pain. He observed changes to the thymus gland which probably reflected stress resulting from severe disease. There was no sign of infection in the abdominal cavity or the bony skeleton, with no sign of any recent trauma.

Dr Sinton stated that he believed any relationship between splenic torsion and the development of acute meningitis was unclear at autopsy beyond the likely synergistic stress induced conditions. It was his view BC died as the result of acute meningitis, with acute splenic torsion contributing to his death.

Dr Bauert was of the view the splenic infarction resulted

from the torsion, which he believed arose out of the wandering spleen, which would have exposed BC to be vulnerable to torsion.[35] The malfunctioning spleen would then render him very vulnerable to infection. There is also evidence Aboriginal babies are especially susceptible to death following infection which in non-aboriginal babies would be considered mild.[36]

## CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied BC was a five month old baby boy born to his mother at KEMH as a healthy 3.3kg baby. While BC's mother had a significant problem with alcohol prior to his birth it was clear she made great efforts to behave appropriately once BC was born. With the support of the Department it was hoped she would be able to care for BC properly and so win back the confidence of the Department in her ability to care for BC and eventually her other children.

As a result of Wendy's commitment to his care the Department agreed not to formally take BC into care, but rather support BC and his mother in an attempt to foster a healthy family unit.

It is my view the Department put significant effort into

[35] t 21.05.14, p74-75
[36] t 22.05.14, p172

assisting BC and his mother achieve appropriate development. There was constant input with BC and his mother, probably more than on many occasions with a child officially in care of a known competent carer.[37]

BC's mother, Wendy, responded very well to ongoing support, and demonstrated appropriate decision making around BC's care. BC became unwell whilst staying in a Wyndham safe house and his mother responded by alerting the authorities and taking him to hospital. He was transferred to KH and then to PMH where he was treated for three weeks before discharge. All those observing interactions between mother and child were impressed at Wendy's attempts to care for BC appropriately. It was evident Wendy found life in the metropolitan area in PMH very difficult.

BC was discharged, without a diagnosis for the cause of his infection with splenic abscesses, on antibiotics. A distended abdomen had been a feature of BC's life to date. It was hoped his enlarged spleen would resolve once his infection was treated and he had finished his course of antibiotics. He was discharged back to KH and a discharge letter provided by PMH indicating the reason for his illness was undiagnosed and should be followed up, as should his four monthly immunisations, once his antibiotic course was complete. That was due to occur before 11 June 2010, the

[37] t 20.05.14, p33

date of his appointment for review by a paediatrician in KH.

No one who needed to know about 11 June 2010 appointment, other than the visiting consultant, knew about, or the importance of, the appointment. It is not clear if that information was ever provided to Wendy. What is clear is Wendy didn't understand it, if in fact she knew it. I suspect she was of the belief the Department would know of any appointment and ensure she was assisted with her care of BC by prompting for the appointment. English was not her first language and it should have been obvious someone appropriate needed to be aware of the need for BC to be reviewed.

Whatever the reason, the Department was unaware of the appointment, or even the significance of the appointment, and received no information BC was suffering from an undiagnosed condition which required follow up.

Although the discharge letter was addressed to the visiting paediatric consultant at KH, it clearly stated WHC as having an interest in BC. It was not provided to WHC. BC was not known to be in the Warmun area at the time and consequently WHC was not in a position to make enquiries about the whereabouts of Wendy and BC, or that there was any reason they should.

Due to Wendy appearing to care for BC appropriately, and

the desire of the Department to transition her back into a family community, she was allowed to visit Crocodile Hole over the weekend of 12-13 June 2010. Consequently, Wendy and BC did not attend the appointment and, when they did not return from Crocodile Hole, her family case worker assumed there was some difficulty with transport, and did not understand they had missed a critical medical review.

During the following week the seriousness of the fact BC appeared unwell was unappreciated by all those who were in a position to influence Wendy and BC, which due to her isolation made communication difficult.

Once it was understood there may be some concern the nurses at WHC had little success in obtaining relevant information and communication was such they did not appreciate there were outstanding concerns from PMH about BC's ongoing welfare. There was nothing to invoke an emergency response which would have been appropriate and potentially have saved BC's life.

By the time the departmental officers understood it was necessary someone intervene, at least to determine the situation, the condition of BC was extreme. Despite prompt action by the departmental officers, WHC and RFDS, RDH was unable to save his life and it became necessary life support be withdrawn.

BC died as the result of meningitis following serious *Streptococcal pneumoniae* infection.

At post mortem it was discovered he also had splenic torsion which had caused complete infarction of his spleen and so detrimentally affected his immune ability.

I find death arose by way of Natural Causes.

## CONCERNS SURROUNDING THE CARE OF BC

It is necessary to emphasise at the outset BC was not a child *"in care"* within the meaning of the *Coroners Act 1996* (section 3, section 22(1)(a)). This means this inquest is not a mandatory inquest but was held out of concern for the situation which arose surrounding BC's death. The ability to share information about his medical history may well have prevented his death and would have happened had BC been officially subject to a care and protection order with the Department.

I appreciate the Department has been critical of itself, and has been criticised by the Ombudsman for a lack of intervention at crucial times at BC's five months of life. I note s23(3) of the Children and Community Services Act 2004 (WA) (CCSA) would have allowed the Department to request a copy of the PMH discharge letter but the

Department was unaware of its importance to BC's welfare.[38] While this may be seen as an argument BC should have been subject to a care and protection order, it does not appreciate the attempts of those working with Wendy to break the welfare cycle. There has to be some relaxation of strict rules of confidentiality when considering the welfare of children. It is a whole of community issue, not just a disastrous outcome for Wendy and BC.

I am of the view, BC and his mother received substantial support from the Department despite the decision he not be taken into care. I understand the reasons for that decision. It was an attempt to break the cycle of care for Wendy and her family which was ultimately unsuccessful. In reality, whilst the Department was actively supporting Wendy, her care of BC was successful.

The difficulty with BC not being statutorily in the care of the CEO of the Department appears to be one of the reasons for the difficulty in communication between PMH, WACHS and the Department. PMH had no difficulty providing BC's discharge summary to KH, part of WACHS. The difficulty was then the distribution of that information from KH. The notes and fax on file do not support information was distributed appropriately as a fact. Later there was the complete inability of WHC to access critical information which may have saved BC's life.

[38] Submissions on behalf of the Department 24.09.14 para 29

PMH's policy on the providing of information to external parties would imply there is an information sharing expectation for children and community services personnel. However, the process is difficult to follow in a crisis situation and it would be preferable requests for information from relevant parties be facilitated in some way.

I am strongly of the view there must be a simple way to facilitate the sharing of information between health facilities critical to the wellbeing of a child. There had been no difficulty with PMH liaising with the Department about BC's welfare and discharge despite their knowledge he was not in care whilst he was in PMH. There are memoranda of understanding in place and the Department can evoke s23 CCSA when they deem it necessary, but they need to know it is necessary.

In this case, the Department didn't have the information to know it was critical they received information. The fact they were not provided with the PMH discharge summary led them to believe there was no live concern with BC's health and welfare and therefore no need to invoke section 23(3) CCSA.

If the Department had been BC's legal guardian the information would have been provided to the Department. This is no compromise for the death of a child who needed

on going medical input and whose legal guardian was not in a position to understand the information.

Evidence was given during the inquest of significant advances proposed in both communication and practices surrounding the management and co-ordination of health care for the protection of children.

I am also very appreciative of the extensive submissions provided by counsel on behalf of CAHS, WACHS and the Department. While the further investigations undertaken to clarify some of the unanswered factual questions around the appropriate distribution of the PMH discharge letter only served to emphasise the conundrum of needing the information to know it was necessary information (Submissions para 29, 33, 40, 43), they did crystalise the improvements envisaged which would make the sharing of some information automatic.

I am hopeful;

- Communicare[39] (or an equivalent) will facilitate the sharing of information between appropriate medical facilities. I appreciate the issue is still consent to the sharing of that information, however, am of the view that medical information critical to the welfare of a child should not be solely dependent upon the consent of a legal

[39] t 22.05.14, p161

guardian;

- The provision of an additional Aboriginal Health Worker[40] to assist with the communication of information relevant to medical appointments;
- Telehealth,[41] the capacity for medical facilities without senior doctors or tertiary input to access expert medical advice by way of video;
- The Febrile Child Five Years and Under (soon to be the Unwell Child) procedure[42] which recognises the fact children of a young age deteriorate very quickly in circumstances seen in remote areas which makes it necessary to institute emergency responses to assess a situation, rather than wait for the emergency to be confirmed before the response is initiated;
- Increased funding for child health services[43]and;
- The Child at Risk meetings,[44]

will all improve the outcome for Aboriginal children in the North West since the death of BC in 2010.

I wish to make specific reference to an initiative I believe, from the information with which I was provided, would have made the most significant difference in a case like that of BC. That is, the Aboriginal Ambulatory Care Coordination

[40] t 22.05.14, p165
[41] t 22.05.14, p168
[42] t 22.05.14, p171
[43] t 22.05.14, p170
[44] t 22.05.14, p170

outreach program (AACC).[45] It was implemented at PMH as a pilot project from July 2012 and comprises a multidisciplinary team including medical, nursing and administrative staff, as well as a Senior Aboriginal Project Officer, a Senior Aboriginal Social Worker and headed by Dr Edmond, a Consultant General Paediatrician at PMH and a Professor of Aboriginal Clinical Child Health.

The AACC program, in conjunction with the development of a multidisciplinary complex patient discharge planning record for patients with a hospital stay in excess of ten days,[46] should ensure a continuity of care between PMH and child patients such as BC once back in their community. It targets *"out of hospital"* follow up care and includes care co-ordination, communication with primary care providers, outreach services, discharge planning, community nursing and Telehealth (now available at WHC).[47]

The initial program included Aboriginal children in the Perth Metropolitan area, the Pilbara and the Kimberley regions who had any planned hospital follow up and provided significant improvements in outcomes for children referred to the service. It needs to be extended beyond the initial target regions. Its key elements include improving the co-

[45] Submissions on behalf of CAHS, WACHS and the Department 24.09.2014 paras 50-61 and attach 4&5
[46] Attachments 4 & 5 Submissions on behalf of CAHS, WACHS and the Department dated 24.09.2014. I note the extent of the information provided to me was not available to counsel for those parties until after May 2014, the time of the inquest into BC's death.
[47] t 22.05.14, p169

ordination of health care for Aboriginal children, especially the most unwell children with complex care needs and facilitating discharge and after hospital care.

Had AACC been in operation at the time of BC's discharge from PMH in May 2010 it is unlikely he would have missed his review appointment on 11 June 2010 at KH. In the event he had, it is likely he would have been followed up and appropriately reviewed in a timely manner with knowledge of his critical need for review; there would have been no issue he warranted emergency intervention once it was realised he was again unwell; and he would have received input from a consultant paediatrician before 20 June 2010. All of which according to Dr Bauert, were critical points at which BC's eventual death could have been prevented.[48]

**RECOMMENDATION NO. 1**

**I RECOMMEND CONTINUED RESOURCING OF AACC OUTREACH PROGRAM AND ITS EXPANSION TO ALL REGIONS IN WESTERN AUSTRALIA. IT IS OF CRITICAL IMPORTANCE TO THE PROVISION OF A FUTURE FOR ABORIGINAL CHILDREN.**

Other measures that would assist those attempting to provide lifesaving care to children in remote areas were canvased at inquest. I include those recommendations

[48] t 21.05.10, p82

here, which in conjunction with the improved ability to communicate critical health information envisaged by developments since 2010, have the potential to have prevented BC's death. I note some of these measures were in place at the time of BC's death but did not work to ensure distribution of health information (PMH discharge letter) critical to BC's future.

**RECOMMENDATION NO.2**

**I RECOMMEND THE DEPARTMENT TRIAL A PRACTICE REQUIRING ALL MOTHERS SUBJECT TO THE DEPARTMENT'S PRE-BIRTH PLANNING PROCESSES TO NOMINATE A GP (OR APPROPRIATE ALTERNATIVE) FOR THE CHILD FOR FOLLOW UP PURPOSES AFTER BIRTH.**

**RECOMMENDATION NO.3**

**I RECOMMEND WACHS ENSURE THE NOMINATED GP BOTH RECEIVES, UNDERSTANDS AND IS SUPPORTED FOR THE IMPLEMENTATION OF FOLLOW UP INFORMATION AND CARE.**

I say this because in the current case WHC was effectively nominated by PMH as the appropriate GP,[49] but never received the discharge letter, and so was not in a position to communicate its contents to any of the other more relevant care providers at a relevant time.

[49] t 22.05.14, p149

**RECOMMENDATION NO.4**

**I RECOMMEND WACHS CONTINUE TO PROGRESS THE IMPLEMENTATION OF CLINICAL INFORMATION SHARING SYSTEMS TO FACILITATE THE SHARING OF PATIENT INFORMATION ACROSS THE KIMBERLEY, SUCH AS THE COMMUNICARE SYSTEM.**

**RECOMMENDATION NO.5**

**I RECOMMEND THE DEPARTMENT AND WACHS WORK TOGETHER TO CLARIFY THE NEED TO PROVIDE RELEVANT HEALTH CARE INFORMATION TO THE DEPARTMENT FOR CHILDREN NOT "IN CARE" BUT WITH FAMILIES UNLIKELY TO UNDERSTAND THE SIGNIFICANCE OF COMPLEX MEDICAL INFORMATION AND NEEDING ASSISTANCE WITH COMPLYING WITH MEDICAL RECOMMENDATIONS.**

I note WACHS are in the process of identifying potential areas for improvement in the Kimberley after hours remote clinic call out procedure and emergency home and community visits procedure (2013).[50] I do not intend to make a recommendation in that area because circumstances can change so rapidly in remote areas. I am confident WACHS will continue to strive for the provision of appropriate procedures across the remote areas to ensure the safety of its workers in the health care of its clients.

[50] t 22.05.14, p144-146

I am hopeful the proposed Unwell Child procedures[51] will ensure the appropriate provision of information, and access to relevant children for emergency assessment, rather than relying on a confirmation of the necessity to invoke an emergency response before an assessment is possible.

E F VICKER
***Deputy State Coroner***
17 December 2014

[51] t 22.05.14, p172-173