Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 36/17

I, Sarah Helen Linton, Coroner, having investigated the death of ***JDC*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, Central Law Courts Building, 501 Hay Street, Perth*** *on* ***11 October 2017*** *find that the identity of the deceased person was* ***JDC*** *and that death occurred on* ***22 May 2012*** *at* ***Royal Perth Hospital*** *as a result of* ***fungal brain infection and infarction complicating fungal infection of a scalp laceration sustained in a motor vehicle collision*** *in the following circumstances:*

Counsel Appearing:

Sgt L Houisaux assisting the Coroner.
Mr S Pack (State Solicitor's Office) appearing on behalf of the Department of Communities.

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SUPPRESSION ORDER

The deceased's name and any evidence likely to lead to the deceased's identification are suppressed from publication. The deceased is to be referred to as JDC.

INTRODUCTION

1. JDC (the deceased) died on 22 May 2012 at Royal Perth Hospital. At that time she was aged 17 years' and 1 month.

2. In March 2006, when the deceased was almost 11 years old, she had been placed into the care of the Chief Executive Officer of the Department for Child Protection and Family Support[1] (the Department)[2] and she remained so for the period until she turned 18 years old. As the deceased died prior to her 18th birthday, she was still in the care of the CEO of the Department at the time of her death.

3. As a result of being in the Department's care, the deceased's death came under the definition of a death of a 'person held in care' under section 3 of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[3] I held an inquest at the Perth Coroner's Court on 11 October 2017.

4. The documentary evidence included a comprehensive report of the death prepared by the Western Australia Police, with relevant information provided by the Department.[4] The authors of both reports were also called as witnesses at the inquest.

5. The inquest focused primarily on the care provided to the deceased while she was in the care of the Department in the final years prior to her death (particularly her medical care), as well as the circumstances of her death.

BACKGROUND

6. The deceased was born on 4 April 1995 in Port Hedland, Western Australia. She was the second of eight children to her mother. The deceased's family first came to the attention of the Department in 1999. Neglect concerns were considered to be chronic and long standing and included a lack of supervision, exposure to domestic violence, alcohol abuse, physical abuse and housing instability. Both parents served periods of time in prison, and the deceased and her siblings spent time living with various family members.[5]

7. After working with the deceased's mother and extended family for several years, on 10 March 2006 the deceased and four of her siblings were taken into provisional care due to concerns for their welfare and safety. The deceased was 10 years and 11 months' old at that time.[6]

[1] As it was then known.
[2] Since 1 July 2017 the Department is no longer referred to as the Department of Child Protection and Family Support but now forms part of the Department of Communities.
[3] Section 22(1)(a) *Coroners Act*.
[4] Exhibit 1.
[5] Exhibit 1, Tab 18.
[6] Exhibit 1, Tab 18.

8. On 17 May 2006 a two year time limited protection order was made in relation to the deceased. This order was extended twice before being revoked and replaced with a protection order in 2011, to run until the deceased turned 18 years of age.[7]

9. The majority of the deceased's placements were with relative carers in Karratha, Onslow and Paraburdoo. Family members worked with the Department in an attempt to engage and support the deceased, however, she continued to abscond from her placements on a regular basis. The deceased often chose to live at various addresses in the Roebourne Community that were not endorsed by the Department.[8]

10. There were continuing concerns expressed by Department staff regarding the deceased's lifestyle throughout her time in care. She continued to abscond from placements and her actual whereabouts were not always known by the Department. The deceased often refused to attend school and had been reportedly smoking marijuana, drinking alcohol and having sexual relationships from the age of 13 years. There were reports that she was in a relationship with an older man who was violent towards her, but she would not cooperate with any police investigation into that relationship. The deceased was also allegedly involved in violent incidents with other people, which had led her to be treated in hospital for various injuries.[9]

11. The deceased had been involved in criminal behaviour that had resulted in Children's Court orders from the time she was 14 years of age. She spent time in Rangeview due to breach of bail on two occasions. She was on a court order at the time of her death for offences including stealing, aggravated common assault and traffic offences. The order involved community service and weekly reporting. She had been told that this was her last opportunity prior to being incarcerated.[10]

12. By the time the deceased was of high school age she had disengaged from the education system. Efforts were made to encourage her to attend school, including the alternative of boarding school, or to engage in some form of training or employment, but in 2012 she remained disengaged from any form of education or employment.[11]

13. Prior to her death the deceased had chosen to live predominantly with her mother, although she frequently moved between her mother's home and Roebourne, where she stayed with her boyfriend or family members. The Department considered it was limited in its capacity to prevent the deceased from living in these environments, given her past absconding behaviour. Also, while the deceased chose to live in those unendorsed placements the Department at least had greater knowledge of the deceased's whereabouts and was able to continue to provide support to the deceased, including financial support and liaison with other agencies such as the Department of Corrective Services. Further, it was felt that the deceased was of an age at

[7] Exhibit 1, Tab 18.
[8] Exhibit 1, Tab 18.
[9] Exhibit 1, Tab 18.
[10] Exhibit 1, Tabs 18 and 20.
[11] Exhibit 1, Tab 18.

this time where she could leave any environment if she felt unhappy or unsafe.[12]

Health and Medical Care

14. The report provided by the Department indicates that the deceased did not have any known medical conditions or illnesses requiring ongoing medical care. In particular, and relevant to later events, she did not present with symptomology for diabetes and did not receive treatment for the same. Department records do not indicate any of the deceased's siblings having a history of diabetes either. However, it is noted that there is no routine testing for children for diabetes (either in care or generally in the community), although there are rules requiring annual health assessments.[13]

15. While attempts were made to engage the deceased in annual medical and dental check-ups, the deceased would often not attend appointments and also would abscond from hospital prior to her treatment being finalised. This made monitoring her health difficult. The Department did provide support to the deceased to access medical care as required, including scheduling appointments, assisting the deceased with transportation and payment of medical costs. In the last two years of her life, the deceased's primary documented medical care involved treatment for injuries.[14]

16. On 7 October 2010, when the deceased was 15 years of age, she was brought to Roebourne Hospital by her family after she had fallen in a ditch while intoxicated. The deceased had sustained a deep scalp wound to the left front of her head. She denied any loss of consciousness or headache. The wound was stitched under local anaesthetic and she was commenced on antibiotics before being discharged.[15]

17. On 6 November 2010 the deceased returned to Roebourne Hospital, with injuries allegedly occurring during an assault by her boyfriend. The injuries included a laceration to the right side of her scalp and right palm, as well as bite marks on her right arm and various lumps, grazes and bruises to her body. She refused any treatment, including any cleaning of her wounds, and also refused to be transferred to Karratha Hospital for treatment. The deceased was advised as an alternative to go to the Women's Refuge and be assessed by a doctor the following day but she also declined to take this advice and was eventually discharged home against medical advice.[16]

18. On 17 February 2011 the deceased was arrested for breaching her bail conditions and was collected by her case worker the following day. The deceased had noticeable cuts to her face, one of which was covered in pus, and she advised the case worker that she had been in a fight in Roebourne the previous week with a local girl who had "glassed" her. The deceased stated she did not seek medical attention at the time of sustaining the injuries. The case worker took the deceased to Nickol Bay Hospital for

[12] Exhibit 1, Tab 18.
[13] Exhibit 1, Tab 18.
[14] Exhibit 1, Tab 18.
[15] Exhibit 1, Tab 15.
[16] Exhibit 1, Tab 15.

treatment. The doctor advised the deceased that she had a serious infection due to not receiving proper medical attention at the time of the incident. She was given a course of antibiotics and her wounds were cleaned and dressed. The case worker arranged for a nurse to then undertake daily home visits to redress the wounds.[17]

19. In November 2011 the Department scheduled two optometrist appointments for the deceased and arranged transport, but the deceased was not home when workers arrived to collect her so she did not attend either appointment.[18]

20. Case workers had also attempted to get the deceased to attend medical appointments with her general practitioner with regards to her sexual health but they had been unable to get her to attend due to her transient behaviour and lack of engagement.[19]

THE MOTOR VEHICLE CRASH

21. In the early hours of the morning on 19 April 2012 the deceased was at a party being held in a house in Nickol Bay. The deceased's uncle was also at the party, where he had been drinking alcohol. At about 5.30 am the party started to slow down and people started to leave. The deceased's uncle started to walk to his car to have a sleep and sober up. As he was walking to his car the deceased came up to him and asked him for a lift to Roebourne. The deceased's uncle told the deceased that he was too drunk to drive, which she acknowledged. The deceased's uncle then got into the passenger side of his car, which was a white Toyota Hilux. He intended to lay down the passenger seat so he could sleep.[20]

22. At the same time the deceased got into the driver's seat of her uncle's car. The deceased did not at that time hold a driver's licence, and indeed she had never held a driver's licence of any class. Nevertheless, she had been convicted of traffic offences in the past, indicating that she knew how to drive a motor vehicle and was prepared to do so without a valid licence. The deceased's uncle had apparently left his keys in the ignition of his car, and once in the driver's seat the deceased used the keys to start the car.[21]

23. The deceased told her uncle that she wanted to go and see her boyfriend in Roebourne. He later told police that he was too drunk to tell her not to drive or to stop her at that stage. The deceased began to drive the car towards Roebourne while the deceased's uncle fell asleep.[22]

24. As the deceased was driving the Hilux towards Roebourne another car was travelling behind the Hilux. The car was a hire car driven by Adam Beard.

[17] Exhibit 1, Tab 18.
[18] Exhibit 1, Tab 18.
[19] Exhibit 1, Tab 18.
[20] Exhibit 1, Tab 11.
[21] Exhibit 1, Tabs 9, 11 and 20.
[22] T 6; Exhibit 1, Tab 11.

Two of Mr Beard's work colleagues were passengers in his car and they were all travelling to work.[23]

25. At about 6.00 am it was still dark but the weather was fine and visibility was generally good. Mr Beard stated that around this time he was travelling along a straight stretch of road, about 5 kilometres from Roebourne, and he could see the rear lights of the Hilux. Mr Beard observed that the tail lights of the Hilux suddenly went from left to right, as if the car was swerving. The lights then rotated in a clockwise direction as the Hilux began to roll over several times. The Hilux eventually landed upside down on the right hand side of the road with the front end facing away from Roebourne.[24]

26. Mr Beard stopped his car on the left hand side of the road and he and his passengers ran over to the Hilux to check on the occupants. The car was severely damaged and there were a lot of alcohol bottles and cans in and around the car, with the smell of alcohol in the air. They saw the deceased seated approximately 10 metres away from the car and she was screaming. Mr Beard then saw the deceased's uncle crawl from the car. Mr Beard called the police and reported the crash and then assisted with traffic management while they waited for police to arrive.[25]

INITIAL MEDICAL TREATMENT

27. When ambulance officers arrived at the scene at 6.15 am the deceased was reported to be very abusive and smelled of alcohol. She was noted to have multiple cuts and abrasions but the ambulance officers were unable to do a secondary survey as the deceased refused to be touched and became violent. The deceased was eventually convinced to get in the ambulance. The ambulance departed the scene at 6.29 am and transported the deceased to Roebourne Hospital, arriving at 6.34 am.[26]

28. On arrival at Roebourne Hospital the deceased had a Glasgow Coma Score (measure of conscious state) of 15/15. She was noted to have a boggy open laceration on her right forehead, one broken tooth and a bloody mouth. There were also multiple abrasions observed on her chest and abdomen. No obvious bone fractures were found on examination but she screamed when touched. She smelled of alcohol and was verbally and physically aggressive towards hospital staff. She continued to refuse spinal mobilisation and oxygen.[27]

29. By 7.15 am the deceased's GCS had dropped to 13/15, which given her history of a high speed crash and obvious head trauma raised concerns of a head injury. The attending nurse called the Emergency Department doctor at Nickol Bay Hospital, Dr Lok Sing, who advised that the deceased should be

[23] Exhibit 1, Tab 12.
[24] Exhibit 1, Tab 12.
[25] Exhibit 1, Tab 12.
[26] Exhibit 1, Tabs 13 and 15.
[27] Exhibit 1, Tab 15.

immediately transferred to Nickol Bay Hospital. She was subsequently sedated and conveyed by ambulance to Nickol Bay Hospital.[28]

30. At 8.10 am the deceased was assessed by Dr Kengi Koay at Nickol Bay Hospital. Her GCS was assessed at 14/15; she was drowsy but rousable and intermittently combative. Further sedation was given to enable examination and radiology. The deceased's blood sugar level (BSL) was found to be 26.6mmol/L with high glucose levels noted on a urine dipstick but with no ketones. Based on the results Dr Koay queried the possibility that the deceased was diabetic.[29]

31. Dr Koay's examination of the deceased's head found wounds to her right forehead and right cheek and a degloving injury (section of skin torn away) to the left parietal area of her scalp, as well as marked swelling around her right eye and right side of her face. She also had a deep laceration to her knee, laceration to her outer left ankle and minor abrasions to her torso. The deceased's wounds were cleaned and moist dressings applied. She was given intravenous broad spectrum antibiotics to help prevent infection as well as intravenous fluids and further sedatives. Imaging by CT scan and x-ray found fractures to the bones around the deceased's right eye and cheekbone, and a possible small fracture in the right side of her pelvis.[30]

32. The deceased's admission bloods showed a blood alcohol level of 0.123% (which as well as being relevant to her ability to drive a vehicle, was also notable in the medical sense to her elevated blood sugar levels as a high blood alcohol level tends to lower blood sugar levels, meaning the actual levels may have been even higher). Her blood sugar level remained high at 11.20 am and she was given 5 units of insulin subcutaneously.[31]

33. The deceased's case was discussed with a Trauma Registrar at Royal Perth Hospital (RPH) and they agreed to accept the deceased into their care. The deceased was transferred by the Royal Flying Doctor Service to Royal Perth Hospital.[32]

MEDICAL TREATMENT AT ROYAL PERTH HOSPITAL

34. The deceased was brought by ambulance to RPH in the early evening of 19 April 2012. On admission her GCS was 15/15. In the Emergency Department she was given a further dose of broad spectrum antibiotics and a tetanus injection. She was admitted to the State Major Trauma Unit.[33]

35. The following day the deceased underwent open reduction and internal fixation of the facial bone fractures. The scalp wounds were debrided and a vacuum-assisted closure (VAC) dressing was applied.[34]

[28] Exhibit 1, Tab 15.
[29] Exhibit 1, Tab 21.
[30] Exhibit 1, Tab 21.
[31] Exhibit 1, Tab 21.
[32] Exhibit 1, Tab 21.
[33] Exhibit 1, Tab 16.
[34] Exhibit 1, Tab 16.

36. On 23 April 2012 further washout and debridement of the scalp lacerations was undertaken together with primary closure. Post-operatively the deceased appeared to make good progress and her antibiotics were continued. However, the deceased was noted to be absent from the ward on a number of occasions for prolonged periods of time. This in turn led to difficulties in maintaining optimum medical management, including antibiotic administration.[35]

37. On 25 April 2012 the deceased again left the ward and did not return at the agreed time. A note was made by the Trauma Intern that the deceased should not be allowed to leave the ward the following day until she had been reviewed by medical staff. She was spoken to by the Trauma Intern the following day and was noted to be very aggravated and she indicated she wanted to return to Karratha. A plan was then discussed to transfer her to Nickol Bay Hospital.[36]

38. On 27 April 2012 the deceased's care was handed over to the Maxillofacial/Plastics team. She was reviewed and it was noted that her right eye remained swollen but her wound looked dry. Regular saline eye baths were indicated due to the possibility of an infection, and swabs were sent for testing.[37]

39. On 30 April 2012 the deceased was reviewed by Maxillofacial/Plastics medical staff and she complained of a pain in her neck. A 1cm defect in her left scalp wound was noted and a report came back showing that the swabs taken from her right eye a few days before showed bacterial growth. A review was done by the Trauma Team and the deceased's possible infected wound was noted. Further surgery was contemplated after the deceased had undergone a CT scan. The CT scan showed a fluid filled collection overlying the deceased's cheekbone and scalp. No intracranial (brain) abnormality was seen.[38]

40. The following day the deceased began complaining of pain at the site of the scalp laceration and asked nursing staff for pain relief. Her observations remained stable and she was recorded as afebrile. The Trauma Team Ward Round found an area of necrosis (wound breakdown) of her left scalp wound and the deceased was returned to the operating theatre. The operative notes indicate the deceased had an underlying abscess to the left scalp wound. The wound was cleaned and debrided to remove dead tissue and a new VAC dressing was applied.[39]

41. During the Trauma Team review on 2 May 2012 the implications of the infection were discussed with the deceased and plans were then made over the following days for plastics review in relation to the need for a possible skin graft or flap. The deceased underwent further surgery to her scalp wound on 4 May 2012, at which time the scalp defect was noted to have increased in size. She remained afebrile and stable over the following days

[35] Exhibit 1, Tab 16.
[36] RPH Medical File, Inpatient Case Notes, 25.4.2012 & 26.4.2012.
[37] RPH Medical File, Inpatient Case Notes, 27.4.2012.
[38] RPH Medical File, Inpatient Case Notes, 27 - 30.4.2012.
[39] RPH Medical File.

but was uncooperative and abusive to nursing staff in relation to dressing changes.[40]

42. The deceased was scheduled for Maxillofacial/Plastics surgery on 8 May 2012 but the surgery was postponed to the following day, when the scalp wound was debrided. The deceased refused observations on her return to the ward and was then noted as absent from the ward later that evening.[41]

43. She refused an examination of the wounds on her lower limbs the following day during the Trauma Team Ward Round and the risk of infection was explained to her. The deceased was also recorded as uncooperative with nursing care that day and frequently off the ward.[42]

44. On 11 May 2012 the deceased recorded a temperature of 39.5°C and indicated she felt unwell. Her VAC dressing was noted to be leaking but she refused removal of the dressing on the ward due to discomfort. She also refused to have blood taken for cultures but allowed a urine sample to be sent. Her IV antibiotics were continued and the deceased was booked for the operating theatre for the following day. Her wound was cleaned and debrided and the VAC dressing changed in theatre the following day.[43]

45. On 13 May 2012 the deceased had an increased temperature and heart rate. A septic screen was performed. She continued to have a fever the following day and the Trauma RMO discussed her case with the Microbiology Registrar. A plan was made to commence a different broad spectrum IV antibiotic and repeat blood cultures, but the deceased refused the blood cultures. She was upset and verbally aggressive to nursing staff at times due to increased pain levels and resistant to wound reviews. The deceased was commenced on patient controlled analgesia (fentanyl) that evening.[44]

46. On 15 May 2012 the deceased complained of pain and refused all observations. She was noted to be afebrile since the new antibiotic had been commenced. [45]

47. On 16 May 2012 the deceased was restless and extremely agitated but made no specific complaints of pain. There was a noticeable increase in her temperature to 40°C, which was associated with metabolic acidosis of uncertain cause. Her VAC dressing on her left scalp was removed and the edges of the wound were necrotic and pus was found. An urgent cranial CT was arranged and she was admitted to the Intensive Care Unit for correction of her metabolic acidosis. A possible diagnosis of diabetic ketoacidosis with underlying sepsis was noted and an insulin infusion was commenced.[46]

48. The CT scan found evidence of possible infection of the bone of the skull and possible swelling and infection of the brain underlying the left scalp wound. She underwent neurosurgery review later that evening and review by a

[40] RPH Medical File, Inpatient Case Notes, 1.5.2012 – 4.5.2012.
[41] RPH Medical File, Inpatient Case Notes, 8.5.2012 – 9.5.2012.
[42] RPH Medical File, Inpatient Case Notes, 10.5.2012.
[43] RPH Medical File, Inpatient Case Notes, 11.5.2012 – 12.5.2012.
[44] RPH Medical File, Inpatient Case Notes, 13.5.2012 – 14.5.2012.
[45] RPH Medical File, Inpatient Case Notes, 15.5.2012.
[46] Exhibit 1, Tab 16; RPH Medical File, Inpatient Case Notes, 16.5.2012.

Plastics Consultant. The deceased was taken into theatre where debridement of the scalp and skull was performed and multiple tissue samples were sent for urgent microscopy. The following day the microscopy indicated fungal spores (zygomycetes) were seen on the specimens and after discussion with a microbiologist the deceased was commenced on intravenous antifungal medication.[47]

49. She experienced ongoing fevers over the following days and on the afternoon of 19 May 2012 a family meeting was conducted with the ICU Registrar to discuss the deceased's poor prognosis.[48]

50. On 21 May 2012 the deceased was noted to be haemodynamically unstable and an urgent CT scan confirmed a large infarction (death) of brain tissue with swelling and likely brainstem death. Brainstem testing was performed the following day and brainstem death was confirmed by an ICU Consultant at 9.48 am. Life support was then ceased.[49]

CAUSE AND MANNER OF DEATH

51. On 25 May 2012 Forensic Pathologists Dr D. Moss and Dr A. Hewison performed a post mortem examination of the deceased. The brain was then submitted for formal neuropathological examination. Neuropathological examination was undertaken by Dr V. Fabian on 31 May 2012 and 1 August 2012, with some assistance from Dr A. Hewison.[50]

52. During the post mortem examination it was noted that the major internal organs showed changes that would be in keeping with sepsis and/or "shock." The post mortem examination also found a large defect within the scalp and underlying soft tissues with erosion of the underlying skull bone. Microscopic examination of tissues confirmed the presence of extensive inflammation and fungal infection within the scalp.

53. The neuropathological examination of the brain showed expansion of the left cerebral hemisphere associated with purulent material in the left parietal lobe as well as widespread swelling and features of transtentorial herniation. Microscopic examination of the brain showed widespread angioinvasive fungal elements in the left cerebral hemisphere associated with secondary infarction of the left frontal, temporal and parietal lobes. The microbiology report from RPH in relation to a scalp tissue specimen, showing growth of *Apophysomyces variabilis*, was in keeping with the fungal elements seen on the neuropathology microscopy. There were recent hypoxic ischaemic changes in the cerebellum.[51]

54. At the conclusion of all investigations Dr Moss and Dr Hewison formed the opinion the cause of death was fungal brain infection and infarction

[47] Exhibit 1, Tab 16.
[48] RPH Medical File.
[49] Exhibit 1, Tab 16.
[50] Exhibit 1, Tabs 4 – 8.
[51] Exhibit 1, Tab 6.

complicating fungal infection of a scalp laceration sustained in a motor vehicle collision.[52]

55. I accept and adopt the conclusion of Dr Moss and Dr Hewison as to the cause of death.

56. I find that the manner of death was by way of accident.

QUALITY OF SUPERVISION, TREATMENT AND CARE

57. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

58. In particular, the deceased's family expressed concerns to this Court in regard to:

i. How the deceased was able to leave the ward and the hospital when she was so unwell;
ii. Why the fungal disease was not detected at an earlier stage;
iii. Why the deceased's dressing was not changed more frequently; and
iv. A perceived lack of communication between the hospital and the Department.

I have attempted to address these concerns as part of my overall assessment of the supervision, treatment and care set out below.

59. From my perspective, the evidence before me raises two major areas of concern in relation to the deceased's treatment, care and supervision. The first is how the deceased was able to have diabetes without it being diagnosed while she was in the care of the Department, and the second relates to the standard of the medical care provided to the deceased prior to her death.

60. The deceased's life had been troubled from a very early age, with allegations of abuse and neglect involving family members substantiated and leading to the deceased and her siblings being taken into the long term care of the Department. After being taken into care there were efforts made to place her with extended family and provide her with structure and support but the Department's records suggest that from as young as 13 years of age she was engaging in risky behaviour and lifestyle choices, including drug and alcohol misuse, criminal behaviour and an intermittent dangerous relationship with a violent older man. For most of her teenage years she was not engaged in school or training and appeared to have no real structure or boundaries in her life.

61. Ms Fiona Fischer, who is employed by the Department of Communities as the Acting Executive Director for Country and Therapeutic Services in the Child Protection and Family Support Division, gave evidence at the inquest

[52] Exhibit 1, Tab 4.

about the care provided by the Department to the deceased. Ms Fischer acknowledged that the Department had a long period of involvement with the deceased, as well as continuing involvement with her younger siblings.[53]

62. Ms Fischer expressed the opinion that the Department provided a lot of support to the deceased but indicated that there were challenges in persuading the deceased to accept the support that was offered, including her choice not to stay in placements that were provided to her, and instead self-selecting where to live.[54] Ms Fischer noted that these challenges with placements can be quite common with young people, particularly as they reach their teenage years, and unless they meet the threshold for secure care admission then the Department can't force them to be in the preferred locations. Instead, Ms Fischer stated that the "Department can offer them support services and care and hope that they make good choices from what we offer."[55]

63. In addition to housing placements, the Department also had a lot of contact with the deceased in relation to medical treatment, and Ms Fischer noted that attempts had been made to get the deceased to see her medical practitioner regularly but she often didn't attend the appointments that were made, including appointments with an optometrist. Attempts to get the deceased to have an annual health check were made, but without the deceased's cooperation they were not in a position to force her to attend.[56]

64. Ms Fischer had reviewed the deceased's case file and noted that in the three months prior to her death, the deceased had 11 contacts with her case worker, which Ms Fischer observed was quite a lot of contact for a 17 year old. A lot of that contact involved encouraging the deceased to attend school or re-engage in a training program, but she also chose not to do that.[57]

65. I accept that there are limits to what the Department can do to provide support and care to a child where the child does not wish to accept that support, and that is particularly true of older children, such as the deceased. Based upon my review of the available materials, I accept that the Department made appropriate efforts to try to provide safe housing, regular medical care and educational support to the deceased, but their efforts were not always successful due to the deceased's unwillingness to engage with their services. Ms Fischer noted that they have had better success with the deceased's younger siblings and she suggested that it might be that it was due to her age and the complex trauma she had suffered that the deceased was less able than her siblings to accept the support offered. This is likely to be true and is indicative of the ongoing harm that can be caused by early childhood trauma

66. Dr David Hurley, who is an Endocrinologist at the Department of Endocrinology & Diabetes at RPH but was not involved in the deceased's medical care, was requested by this Court to review the medical records of

[53] T 8.
[54] T 8.
[55] T 8.
[56] T 9.
[57] T 9 – 10.

the deceased and provide an opinion as to her medical management in view of her raised sugar levels (suggesting undiagnosed diabetes) and whether her sugar levels may have contributed to the development of her wound infections and subsequent death.

67. After reviewing the materials provided Dr Hurley provided a written report to the court. Dr Hurley also gave oral evidence at the inquest. Dr Hurley considered that it was very likely that the deceased had diabetes well before the motor vehicle crash. Her diabetes was then aggravated by the expected 'stress response' to illness, in which high levels of adrenaline, cortisol and other hormonal changes greatly increased glucose production by her liver, as well as antagonising the effects of insulin on other tissues, especially muscle.[58]

68. Dr Hurley indicated that it is often the case that diabetes may be present without having been diagnosed, and it is likely this was the case with the deceased. As the deceased was Aboriginal, it was much more likely that she had the type 2 form of diabetes, although type 1 diabetes (which is unusual, but not unknown, in Aboriginal people) or insulin deficient diabetes caused by pancreatic disease (often caused by excessive alcohol use) were also possible.[59] Dr Hurley stated the type of diabetes may not have been important to the management of her diabetes during her illness, as insulin was clearly needed.[60]

69. Dr Hurley's review of the RPH medical records found that her hyperglycaemia (high blood glucose levels) was recognised early "and managed appropriately and well."[61] However, despite early, intensive and effective management of her hyperglycaemia, this management was unfortunately unable to prevent or overcome the progressive, severe fungal infection.

70. Dr Hurley explained that the type of fungal infection found "is known to occur in people with poorly controlled diabetes who are malnourished and who have other medical problems,"[62] as applied in the deceased's case. Therefore, Dr Hurley expressed the opinion that the deceased's previously undiagnosed and untreated diabetes, and her general suboptimal health and nutrition, would have compounded her injuries and contributed to her progressive, and ultimately fatal, fungal brain infection.

71. Based upon the available medical history Dr Hurley believes the deceased had diabetes for much longer than was realised and thought it probably went back quite a long time, certainly for months and quite possibly for years.[63] Dr Hurley noted that the deceased was at risk of developing diabetes from a genetic point of view because she was Aboriginal, and it is possible she was also exposed to environmental factors that could have increased the likelihood that she would develop diabetes. Some of these factors can include

[58] Exhibit 1, Tab 17.
[59] Exhibit 1, Tab 17.
[60] Exhibit 1, Tab 17.
[61] Exhibit 1, Tab 17, p. 2.
[62] Exhibit 1, Tab 17, p. 2.
[63] T 11 – 12, 15.

being overweight and alcohol abuse, which were indicated in the deceased's history.[64]

72. Dr Hurley observed that a lot of people in the community have diabetes and don't know it, and that is true in all populations. He noted that it is a shame because undiagnosed diabetes can cause a lot of harm. In the case of the deceased, Dr Hurley expressed the opinion it was most likely that she had type 2 diabetes, although he also thought it could be partly type 1 diabetes.[65] Type 1 diabetes must be treated with insulin, whereas type 2 diabetes can be treated with diet, exercise and oral medication although there are some people with type 2 diabetes who also require insulin, and Dr Hurley believed the deceased might have been one of those people.[66]

73. When the deceased first received medical treatment after the crash he believes her diabetes was picked up reasonably quickly in the sequence of events, and it was acknowledged then that her blood sugars were very high and appropriate treatment was instituted.[67] She was given insulin without delay and an appropriate amount, but her blood glucose levels were rarely normal thereafter, despite all the medical practitioners doing what they could. In those circumstances, Dr Hurley believed the deceased was probably resistant to insulin, which can be part of the condition and is part of the problem with type 2 diabetes.[68]

74. Dr Hurley noted that advice and assistance from the RPH Department of Endocrinology and Diabetes Department could have been sought regarding the nature and management of the deceased's diabetes, but was not. However, Dr Hurley also expressed the opinion that everything reasonable was done to manage the deceased's diabetes but after having undiagnosed diabetes for so long it was difficult to manage and the diabetes then suppressed her ability to fight infection.[69] In addition, Dr Hurley noted that the infection is particularly common in people with very poor nutrition and very bad lifestyles, where the defences are significantly compromised and impair the normal ability to fight the infection.[70]

75. Dr Hurley was asked his opinion whether things might have been different if the deceased's diabetes had been diagnosed and managed better prior to the crash. He agreed that it certainly could have made a difference but also noted that controlling type 2 diabetes is difficult at any age and requires people to "do the right thing"[71] and change their diet, exercise, stop smoking and drinking alcohol, lose weight, take medication and generally live a healthy lifestyle. Dr Hurley observed that it "is very hard to do, and a lot of people are not able to do it as well as they should do."[72] Therefore, in this case there is a real possibility that even if the deceased had been diagnosed with diabetes at an earlier stage, she may have found it very difficult to

[64] T 14.
[65] T 15.
[66] T 16.
[67] T 12 -
[68] T 16.
[69] T 16.
[70] T 17.
[71] T 18.
[72] T 18.

manage her condition. Although without a diagnosis the deceased never got the chance to demonstrate whether she was willing to change her lifestyle, the evidence before me of her general resistance to attending medical appointments and follow through with medical treatment plans, as well as her resistance to care while an inpatient prior to her death, does give me some concern as to whether she would have been able to do so.

76. I note the comment of Ms Davis, the Executive Director of the Department's Country Services and Therapeutic Care division, that the Department, like any other parent or guardian "is limited in its capacity to influence the choices by a young person who does not view her parent's wishes of being of any influence."[73] In the case of the deceased, I am satisfied that even if the Department had been able to facilitate the deceased attending earlier medical appointments that might have led to a diagnosis of diabetes, the Department would have been limited in its ability to change her lifestyle without her cooperation.

77. In these circumstances, I am satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death.

CONCLUSION

78. The deceased was a deeply troubled young girl who, despite being taken into the care of the Department, remained at significant risk of physical and emotional harm due to her ongoing risk-taking behaviour and inability/unwillingness to engage with the services provided by the Department.

79. The deceased was nearly an adult when she made a decision to drive a vehicle when she was not qualified to do so and intoxicated. She was subsequently involved in a traffic accident. She sustained injuries that were appropriately treated, but were complicated by her undiagnosed diabetes and, at times, her unwillingness to follow medical advice. Sadly, she developed a serious infection, which ultimately caused her death.

S H Linton
Coroner
20 November 2017

[73] Exhibit 1, Tab 18, p. 8.