Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 03/17

*I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of **KLD** with an Inquest held at Kalgoorlie Coroners Court, Court 4, Hannan Street, Kalgoorlie, on 12-13 January 2017 and Perth Coroners Court, Court 51, CLC Building, 501 Hay Street, Perth, on 16-18 & 20 January 2017 find the identity of the deceased child was **KLD** and that death occurred on 22 August 2012 at Princess Margaret Hospital, Subiaco, as the result of Hypoxic Ischaemic Encephalopathy following Unexplained Cardiac Arrest in the following circumstances:-*

Counsel Appearing:

Ms K Ellson assisted the Deputy State Coroner

Ms R Hartley (State Solicitors Office) appeared on behalf of the Department for Child Protection and Family Support, WA Country Health Service & Princess Margaret Hospital

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SUPPRESSION ORDER

The name of the deceased and any identifying information are suppressed from publication. The deceased is to be referred to as KLD.

INTRODUCTION

On 16 August 2012 the deceased child (KLD) participated in a supervised contact visit with her biological parents between approximately noon and 1pm. She was returned to her relative (foster) carers at approximately 1.00 pm and at 2.07 pm was taken by her foster mother to the Kalgoorlie Regional Hospital (KRH) in an unresponsive state. KLD was stabilised, transferred to Princess Margaret Hospital (PMH) by the Royal Flying Doctors Service (RFDS) and placed in the intensive care unit (ICU). Following intensive investigations it was concluded KLD could not survive independently and life support was withdrawn. She died on 22 August 2012 at 21 months of age.

KLD was in the care of the CEO of the Department for Child Protection & Family Support (DCP)[1] and had been with her foster carers since March 2012. It is the fact of her being in the care of the DCP which mandates an inquest into the circumstances of her death pursuant to section 22 (1) (a) (WA) *Coroners Act 1996*. Where an inquest is held in these circumstances the coroner must comment on the supervision, treatment and care of that child while in that care (section 25 (3)).

BACKGROUND

The deceased was born on 17 November 2010 in KRH to her biological parents. KLD had an older brother from the same parents, approximately three years her senior. They had three older half siblings through their mother and DCP had been involved with the extended family from 1999. Both of their parents had been in DCP care in their own childhoods.

KLD had first come to the DCP's attention when her brother was found wandering the streets, unsupervised, in April 2011. Attempts by DCP to put in place safe parenting strategies for the two children were unsuccessful due to the failure of KLD's biological parents to attend meetings or engage with DCP.

[1] The use of the abbreviation DCP is to refer to any relevant child welfare government body responsible for children in care at any point in time during KLD's life.

DCP records indicate that in May 2011 the children were exposed to a family violence incident, however, were themselves safe and well. DCP commenced further investigations by arranging unannounced home visits, but were always unsuccessful in locating the family. Further arranged meetings between the biological parents, and DCP were again unsuccessful, due to the children's biological parents not attending at prearranged times, and DCP staff being unavailable when the parents did choose to attend. DCP Joondalup office was involved and a decision was made to try and provide the family with a *"child centred family support"* (CCFS) team with a team leader to try and assist the biological parents in parenting the children in an appropriate way. It became apparent there were also housing concerns for the family.

There was another domestic violence incident in June 2011 which again appeared to have been in the presence of the children, although the children had presented as healthy and calm.

The Crisis Care Unit (CCU) performed a joint home visit with WA Police that night to check on the home circumstances and ensure the biological mother obtained appropriate medical input. The issue of the children's exposure to drinking and violence was discussed with their biological parents.

KLD's biological parents were not prepared to provide DCP with new addresses, nor did they provide follow up telephone contact when requested. DCP staff attempted to locate the children by visiting various addresses, but were unable to find them. Due to the ongoing concerns with appropriate parenting and homing it was decided in June 2011 the children would be taken into care under the then Children and Community Services Act 2004 (CCS).

A safety and wellbeing assessment (SWA) approved outcome report, dated 29 June 2011, recommended neglect and emotional harm in relation to the children be substantiated, and that the lack of engagement with DCP in an attempt to assist the family exposed the children to further harm. It was recommended that once located they be taken into care under section 37 CCS.[2] From June to September 2011 DCP attempted to locate KLD and her brother. Eventually they were found and placed into the care of the CEO of DCP.

Following their apprehension the children were placed with a non-aboriginal general foster carer in Joondalup while DCP attempted to identify and assess appropriate cultural care. KLD and her brother did very well with their general foster carer, as confirmed by both their biological parents.[3]

Unfortunately, there were difficulties for the carer with access visits requiring supervision by DCP due to frequent

[2] Ex 2, tab 6
[3] Ex 1, tab 5 & Ex 1, tab 6

nonattendance by the biological parents. DCP noted the interaction between the children and their biological parents was good on the occasions their biological parents attended visits, but there was concern with the consistency of those visits.

In September 2011, shortly after the children were taken into care, KLD was reviewed by her GP in Joondalup who recorded KLD appeared to present normally for her age and that her immunisations were up to date. He noted a discharge from both KLD's right and left nostril, although she did not appear to have an infection in either her ears or throat. She was again provided with immunisations in December 2011 without query as to her progress and in February 2012, prior to transfer to Kalgoorlie, she was provided with further immunisations and no further concerns noted.

KLD's biological parents were having difficulty with housing and eventually moved to Kalgoorlie with family, which made it very difficult for them to visit KLD and her brother. They informed DCP they would prefer the children be provided with carers in Kalgoorlie to make access visits easier. DCP was unable to locate departmental carers and worked with KLD's biological parents in an attempt to find appropriate relative carers for the two children.

The biological parents were staying with one of KLD's mother's sisters and they noticed her niece and her niece's partner had young children of their own, and appeared to be good parents. KLD's biological mother approached her niece and her partner and asked if they would be willing to care for KLD and her brother. One of their own children was the same age as KLD's brother. The niece and her partner agreed to care for KLD and her brother.

The niece (foster mother) and her partner (foster father) approached the DCP and offered themselves as foster carers for KLD and her brother. They were assessed by DCP to be appropriate relative carers and, following the appropriate assessments, KLD and her brother were relocated to Kalgoorlie into their care on 8 March 2012.

The situation with DCP between March 2012 and June 2012 was that the Joondalup DCP office provided ongoing case management, while the Kalgoorlie DCP office assisted in a co-working role. This was the equivalent of a .5 case manager at each district office.

Around the time the children's foster parents began to care for them their foster mother discovered she was pregnant. Her pregnancy progressed through the time she was caring for KLD and her brother.

KLD's brother started school and, on 3 May 2012, a two year protection order (time limited) was granted to DCP to care for both children. In June 2012 a care plan was put in place for the children at a meeting attended by the Joondalup Case Manager, the Kalgoorlie Case Worker, the children's biological parents and their foster parents. Transfer of the children's care to Kalgoorlie then occurred. This removed the children from the direct supervision of any case manager, due to extreme staff shortages in the DCP Kalgoorlie office. Instead they were placed on a monitored list which at that stage held 100 children. They went from, effectively two DCP employees being involved in their care, to no one, other than, indirectly, a team leader.

DCP continued to provide supervised access visits with the two children and their biological parents. During this time the children's biological parents were requested to participate in various courses to provide them with management and parenting skills.

The children appeared well cared for and the resource worker supervising visits had no concerns with the interaction between the children and their biological parents on the occasions it arose. Similarly, the resource worker noted no difficulty with the children's response to their foster parents. The visits between the children and their biological parents were considered to be safe and discreet

supervision from a distance proved to be appropriate on the occasions the contact visits proceeded.

In June 2012 KLD was taken to KRH due to a concern with her right knee. Her foster mother indicated she had fallen over and hurt her knee. She was reviewed and treated at the hospital. There were no other records for KLD with KRH.

DCP – KALGOORLIE OFFICE

In mid-2012 the Kalgoorlie DCP office was seriously under resourced. Although there were FTEs available, few of them were filled. This caused children considered to be progressing well, being maintained on the monitored list. KLD and her brother were on the monitored list. They had no dedicated case manager, although their Kalgoorlie co-worker with Joondalup had been allocated .5 of a placement while the children were still case managed by Joondalup. On their transfer to Kalgoorlie they lost that .5 of a dedicated case manager, however, came under the auspices of their previous Kalgoorlie .5 co-worker's, team leader, Brenda Bassett.[4] Ms Bassett had provided the original .5 co-worker for the children, and while the children were on the monitored list, that co-worker was seen as a contact point by both the biological parents and the foster parents for contact with DCP in Kalgoorlie. Both the biological parents and the foster parents considered Nadia Antonelli to be their case manager.

[4] Ex 2, tab 8

Due to her workload this was not possible, however, Ms Antonelli did her best to provide a conduit to the resources of the DCP Kalgoorlie office. Ms Antonelli probably knew the most about the children, however, in the structure of the Kalgoorlie office, she was not directly responsible for them and concerns would have been left with the team duty worker and the team leader to implement.[5]

Ms Antonelli indicated the plan with the children was that once an appropriate pattern had been established with the contact visits for the children with their biological parents, progress would be moved towards having the access visits unsupervised at the foster parents' home.[6] Prior to that happening DCP had to be confident the visits were running well. There had been some concern from the foster parents, the biological parents did not always attend contact visits and that tended to cause some confusion for all family members.

Ms Antonelli had attempted to assist the biological parents, particularly when the children were first moved to Kalgoorlie. She attempted to provide them with some assistance in obtaining housing and provided them with SmartRider's for public transport and telephone cards to enable contact with the children.

[5] t 16.01.17, p195
[6] Ex 1, tab 11

Child access visits in Kalgoorlie were usually supervised by a resource worker and the resource worker appointed to KLD and her brother was Denise Stone. Ms Stone would collect the children from their foster parents, take them to wherever the contact visit was to be, supervise that contact from an appropriate distance, to allow the family some independence, while still supervising the contact was appropriate. At the end of the visit the resource worker would take the children from the place of the contact visit and return them to their foster carers. During their time in Kalgoorlie the supervised access visits took place in either Hammond Park or Hungry Jacks depending on the weather and the wishes of the biological parents.[7]

Ms Antonelli advised there were times when there were problems with the access visits in that the children's biological parents did not attend as agreed. Eventually a system was developed whereby the children's biological parents would confirm with Ms Antonelli as to whether they intended to attend the supervised visit, prior to Ms Antonelli confirming with Ms Stone when and where the children were to be supervised.[8]

Ms Stone advised the inquest she considered the access visits between the biological parents and the children to be satisfactory. There was no inappropriate behaviour or

[7] Ex 1, tab 12
[8] Ex 1, tab 11 & t 13.01.17, p153

discussion and the children seemed well cared for when with their biological parents and happy. Ms Stone stated initially in her time with the children she noted that when she collected them from their foster carers' home they were happy and bubbly. KLD "*jigged*" around to the music on the radio in the car and was an active bubbly child.[9]

In May 2012, due to staff shortages, it was necessary Ms Antonelli conduct two access visits with the children herself. She noted KLD had quite a runny nose which she discussed with her foster mother. She was told KLD was being given Nurofen, and she believed there was also a conversation about taking her to the doctor.[10]

In the last six weeks of KLD's life Ms Antonelli had noticed that KLD's biological mother was becoming more uncontactable by telephone and it was reported to her the biological parents had started substance abuse again. The biological parents' scheduled counselling appointments were not being attended and their foster mother was having difficulty managing things with her advancing pregnancy and needed to consider some respite.[11]

SUPERVISED VISITS IN AUGUST 2012

The DCP Kalgoorlie office in 2012 required their family resource workers to complete records of the supervised

[9] t 13.01.17, p140
[10] t 16.01.17, p199 & t 13.01.17, p145
[11] Ex 1, tab 11

access visits to note anything of concern. The requirement was that *"contact feedback"* reports would be submitted for the children to DCP for the information of the children's case worker.

The contact feedback reports stated the names of the children, the date of the access visit, who it was with and where it occurred. The family resource worker would note whether they supervised and/or transported the children, the times of the visit and aspects related to the visit. There was provision to outline child interaction with parents, the various activities conducted, and an additional area for comments and issues.

In early August 2012 Ms Stone had some concerns brought to her attention by KLD's biological parent's as to KLD's apparent change in demeanour. Both biological parents noted KLD appeared to be much quieter and more withdrawn than she had appeared to be earlier in their transfer to Kalgoorlie.

On 2 August 2012 Ms Stone noted that although the children's biological parents had not seen their children for some time the family appeared to relate well to one another. She noted KLD's brother was always happy, but noted KLD as being too young to be excited upon seeing Ms Stone for the supervised access visit, however, both children were happy to see their parents and played well together at

Centennial Park. Ms Stone was very happy with the interaction with the family and thought all behaviours were entirely appropriate.

Ms Stone did record, however, that KLD's biological father was concerned KLD had *"scratches on both sides of her neck"*. It was conveyed to Ms Stone the biological parents had some concerns the foster parents were not as attentive to the children as they would have wished due to there being lumps and bruises on KLD. Ms Stone noted the children did not seem to be upset and ate and played normally.[12]

The next visit was again at Centennial Park on 6 August 2012 and on this occasion Ms Stone noted KLD had little or no expression and that her brother was crying because he had lost a shoe. She specifically noted KLD had little to no expression during the entire contact, although her brother appeared to be very well. Ms Stone noted KLD did not appear to be as happy as she had been earlier in her stay in Kalgoorlie.[13] Again Ms Stone had no concern with the interaction between the children and their biological parents, however, she again noted KLD's biological parents were concerned the children weren't being cared for properly due to the bruises on KLD's cheeks, which Ms Stone noted. In evidence Ms Stone noted the bruises on KLD's cheeks were consistent with her being pinched. Ms Stone noted

[12] Ex 1, tab 16B
[13] Ex 1, tab 16B

KLD was becoming quieter and less responsive to her surroundings. The change seemed gradual, although she had noted it in the contact visits, and quite subtle over a period of time.[14]

KLD's biological father also stated that having noted concerns with KLD he thought *"nothing of it"* once he had been reassured it would be brought to DCP's attention. He believed it was something that happened to children. It was in retrospect it became clear to him there appeared to be an ongoing deterioration in KLD's responses to her environment and that she did not seem to be developing at the same rate as she had been earlier.[15]

On the visit 9 August 2012 at Hammond Park, Ms Stone noted the children interacted very well with their parents and the contact was entirely appropriate. Ms Stone noted both children played, but KLD still did not seem as happy as she had been, although both children ate and drank and responded to the activities provided. Ms Stone noted KLD was *"still very quiet when I took her back",* but did state it could have been because of KLD being tired and as a result she did not think any more of that issue, especially when she raised it with the foster mother who stated she was probably tired.

[14] t 13.01.17, p149
[15] t 12.01.17, p61

With respect to the contact feedback reports, Ms Stone signed the visits of 2 & 6 August on those days. Her contact feedback report for the visit on 9 August appears to have been written on that day, however, is not dated by Ms Stone, and is only dated as noted by Ms Bassett, on 20 August 2012. The two earlier contact feedback reports have not been signed by a case worker.

In evidence Ms Bassett said because the children did not have a Kalgoorlie case worker their contact visit reports were not read in 2012,[16] and that she had only sighted them after the collapse of KLD on 16 August 2012. This was a clear disadvantage to the children in not having an allocated case worker and no appropriate process in place to record their progress. This was largely because the contact visits were considered to be straight forward and that, when the biological parents attended for the supervised contact[17] visits with the children, it was always successful and not an ongoing point of concern for the Kalgoorlie DCP office.

KLD's biological parents did report some comments made by KLD's brother as to KLD being picked upon,[18] and his foster father indicated that KLD's brother sometimes picked on her when in the foster family environment.[19] KLD's foster grandmother indicated that in her view KLD had always

[16] t 16.01.17, p185
[17] t 13.01.17, p150–153
[18] Ex 1, tab 6
[19] t 13.01.17, p164

been quieter than the other children, but noted KLD and her brother were very close.[20]

KLD's biological parents stated they had gone into the DCP Kalgoorlie office from time to time in an attempt to speak to the children's case worker, Ms Antonelli. The children's biological father was concerned that when they attended at DCP offices they were never able to meet with the children's case worker who was always *"busy or attending some meeting"*.[21]

The children's foster parents also indicated it was difficult to contact DCP with respect to concerns relating to the children. They had some discussions with Ms Antonelli about requiring respite care for KLD and her brother during the late stages of their foster mother's pregnancy and birthing.[22] Both sets of parents felt they had difficulty communicating with a case worker. Part of this difficulty appears to have been non-attendance at pre-arranged meetings and unscheduled arrivals at DCP offices in the expectation they would be seen.

16 AUGUST 2012

Contact Visit

On 16 August 2012 Ms Antonelli had confirmed the children's biological parents would be attending the

[20] Ex 1, tab 7
[21] t 12.01.17, p62
[22] t 13.01.17, p176–7

scheduled contact visit. This raised a problem because Ms Stone was not available on that date to supervise the contact visit.[23] The only other family resource worker was already supervising a visit and, as a result, a case support officer, Julie Thomas, was asked to supervise the contact visit in place of Ms Stone. This was not a normal part of Ms Thomas' duties and Ms Thomas had not supervised a contact visit alone before.[24] Ms Thomas did not know KLD or her brother.

In the telephone conversation between Ms Antonelli and the foster mother on the morning of 16 August 2012 the foster mother had advised Ms Antonelli she was becoming stressed with readying the children for their access visits and her own pregnancy medical appointments.[25]

Ms Thomas attended at the address of the foster parents and was met by the children's foster mother who was heavily pregnant. The foster mother's older daughter, a child of approximately 11 years of age, took KLD out to the car on her hip. KLD's brother also came out to the car and Ms Thomas fixed his seatbelt, while the 11 year old girl put KLD in the baby seat. Ms Thomas noted both children looked well-presented and clean and that KLD had a sippy cup with a drink. A back pack was provided by the foster mother for the children.

[23] Ex 1, tab 11
[24] Ex 1, tab 13, t 13.01.17, p126
[25] Ex 1, tab 11

The visit was again at Hungry Jack's that day. Ms Thomas drove to Hungry Jack's and noted nothing unusual about the children. She spoke to KLD's brother who said he was happy to be going to see his parents, although KLD did not speak. Ms Thomas could hear KLD drinking from her sippy cup, she appeared quite thirsty.

Once at Hungry Jack's the children's biological parents came to the car, although Ms Thomas did not introduce herself, but assumed from the children's reaction these were their parents.[26] She noted the biological parents to be interacting very well with the children and the children seemed excited. She noted the responses of KLD's brother more than those of KLD. Ms Thomas noted the parents appeared to be fine, not under the influence of any substances and that the family interacted well. She kept her distance and supervised. She had a clear view of the family at all times, but did not necessarily hear the full conversations. She had been told this was a straight forward visit without problems. Ms Thomas noticed nothing out of the ordinary and the visit appeared to go well for the hour they were there.

In evidence KLD's biological mother indicated she was concerned KLD was particularly quiet and appeared to have an injury of some description on her head because she

[26] t 13.01.17, p130

would not allow her mother to brush her hair which was their normal routine.[27] Both parents noted their son appeared to be well and active, but were both concerned about KLD because she did not seem to be walking or talking as much as she had in the past.[28]

At one point KLD's biological father was at the slide with KLD and her brother. KLD's brother was on the slide and as he came down the slide towards KLD, so she let go of the slide edge and plopped down, on her bottom, between her father's legs. She remained upright and her head was supported by his knees.[29] There was no adverse reaction from KLD although her biological father stated that in the past she had been anxious to be on the slide herself, but she seemed to be no longer interested in participating.

Their biological parents had no concerns about KLD's brother, but were very concerned about KLD, although both agreed they did not mention it to Ms Thomas because she was new and unknown to them. They noted KLD appeared to be very thirsty, drinking a lot of Fanta, but was reluctant to eat and only nibbled on a chip or two. They thought this was unusual. Ms Thomas was told the parents would like more access to the children and they were advised to speak to Ms Antonelli.[30] Ms Thomas believed KLD's biological mother mentioned something about being able to visit the

[27] t 12.01.17, p34
[28] t 12.01.17, p58
[29] t 12.01.17, p57
[30] t 13.01.17, p131

children at the carer's home because they were relative carers.

After the Contact Visit

On the return trip Ms Thomas did not notice anything of concern about the children, although she did note KLD did not want to eat any of her brother's Cheezels, and seemed very thirsty.[31]

On arrival at the foster parents' home, both the foster mother and her daughter came out to the car and Ms Thomas was talking to KLD's foster mother. She noted KLD seemed to be very tired because she was closing her eyes and "*kind of falling asleep*". She discussed this with the foster mother who agreed she must be tired and needed a sleep. The foster mother's daughter took KLD into the house and Ms Thomas did not notice any injuries or coordination problems with KLD, other than the fact she seemed to be very tired.[32] She noted KLD's brother just ran inside and that everything seemed fine with the children's foster mother.

Ms Thomas returned to work and went to lunch before returning to the DCP offices at about 2.15 pm.[33]

[31] t 13.01.17, p132
[32] t 13.01.17, p137
[33] Ex 1, tab 13

In evidence KLD's biological mother confirmed she had been concerned about KLD's presentation on that day and was worried the other children, or the foster family generally, may be picking on her daughter as the smallest in the family. She was aware of her niece's pregnancy and concerned KLD was not receiving appropriate input.

After the visit KLD's biological parents went to the DCP offices in Kalgoorlie and asked to speak with Ms Antonelli.[34] Ms Antonelli was not able to have a meeting with KLD's biological parents, but organised a meeting for the following day to discuss their concerns. She was not advised of any reason for the request for a meeting.

Ms Antonelli remembered a conversation with KLD's biological mother about a request for a meeting as occurring prior to 16 August 2012. However, KLD's biological mother was adamant she went into the Kalgoorlie DCP office immediately after the contact visit to attempt to see Ms Antonelli, but agreed that a meeting had been arranged for the following day.[35]

On KLD's return from the supervised visit her foster mother indicated she was attempting to organise lunch for the children. Her 11 year old daughter was working in the dining room on a project while the two boys were outside playing. She had placed KLD on the couch in the lounge

[34] Ex 1, tab 5
[35] Ex 1, tab 6

room. The floors were tile floors and there was a rug in front of the couch although there was a space between the edge of the rug and the couch. She was in the kitchen preparing the children's lunch.[36] Her partner was at work.

It is not clear precisely when it occurred, however, KLD's foster mother says she heard a sound and KLD called out to her. When she went into the lounge room she found KLD on the ground in front of the couch and picked her up. She noted KLD's eyes to roll back in her head and then she appeared to convulse and stop breathing. Initially she was unsure of what to do, but realised she needed to take KLD to the hospital.[37] She did not have a mobile telephone and so was unable to call for assistance or call for somebody to come and look after the rest of the children. As a result she had to get all of the children into the car before she drove to KRH with KLD.

When spoken to later by the police the other children gave varying accounts which were mostly consistent in that KLD had a fall, albeit from different places, and that she had held her breath and then died. There was also some reference to vomit.

KLD's foster mother was very protective of all the other children, including KLD's brother, when giving evidence and

[36] t 13.01.17, p168–170
[37] t 13.01.17, p166

was adamant that none of the other children were in KLD's proximity at the time of the fall.

KLD's foster mother rushed her to hospital and once there handed her to the emergency department doctors and contacted her partner. The hospital's social worker took care of the other children and it was clear to all staff KLD's foster parents were very distressed and scared during the time they were at the hospital. Staff were concerned about her foster mother's advanced pregnancy.

KALGOORLIE REGIONAL HOSPITAL

The KRH records indicate KLD's foster mother presented at the emergency department (ED) at KRH at 2.07 pm on 16 August 2012.[38]

Dr Brannigan recorded KLD as presenting in full cardiorespiratory arrest with a presumed down time of between 20-30 minutes.

Dr Brannigan first became aware of the situation, while sitting at the work station in the ED, when a nurse ran past his desk calling *"resus"*. He noted she was carrying a small indigenous child. Dr Brannigan and Dr Anderson ran into the resuscitation area and noted KLD was in asystolic arrest, she was not breathing, had no pulse, was non-responsive and completely unconscious. He noted her to be

[38] Ex 1, tab 19

female, approximately 20-22 months of age with no obvious signs of injury. She appeared a little dehydrated as she was a little sunken around her eyes. There was no external evidence to provide a reason for her presentation.

The hospital staff initiated advanced cardiac life support and KLD was intubated and provided with adrenalin via intraosseous access, while Cardio Pulmonary Resuscitation (CPR) was continued.

Circulation and a measurable pulse were regained and Dr Brannigan urgently consulted with the consultant paediatricians for neonates, Dr Murali Narayanan and Dr Rafiq Hemani. Both consultants had attended at the resuscitation cubicles. KLD was managed with the possibility of a non-accidental injury (NAI) in mind. Blood tests and chest x-rays were ordered in an attempt to diagnose her condition, including infection. The clinicians' priority was to stabilise her and have her transported to PMH via the RFDS for appropriate care for a child of her age.

Dr Brannigan attempted to speak to KLD's foster mother and father, who by this time had also arrived, about what had happened to see if that would help in determining a course of action. He noted there did not seem to be an explanation for KLD's presentation, although both foster

carers were visibly upset and distressed about her condition.[39]

Dr Narayanan, Specialist Paediatrician and head of paediatrics at KRH explained that when he examined KLD there were no obvious signs of external injury and no obvious signs of sinister disease. He also asked the foster parents what had happened to KLD and understood she had been for a visit with her biological parents earlier in the day. Her foster mother did not believe KLD was unwell, nor could she say whether she had an injury, and had no explanation as to what had happened.[40]

On hearing KLD was in care the hospital had contacted the team duty worker at the Kalgoorlie DCP office and she advised Ms Bassett of the situation at approximately 3pm. Ms Bassett checked with Ms Thomas as to what she recalled of the supervised visit and was told KLD had looked tired but didn't appear to be seriously ill to Ms Thomas.

Dr Narayanan explained KLD had effectively died but they had managed to resuscitate her and would continue to treat her.

Dr Narayanan was then told KLD's biological parents had arrived at the hospital, having being contacted by DCP, and there was a potential problem with the two sets of parents

[39] Ex 1, tab 15
[40] t 16.01.17, p229

being in contact with one another and they had been separated.[41] Dr Narayanan noted KLD's biological father was very angry and he attempted to talk to her biological parents about what had occurred. Both her parents explained they had seen her at Hungry Jack's and told Dr Narayanan she had appeared tired, wouldn't eat and that she had lumps on her head. Dr Narayanan looked at KLD's head, where he felt four or five small lumps to the back of her head, without obvious bruising or haematomas. He explained in court he could not determine what they were, but there was the possibility that they were enlarged lymph nodes which sometimes occurs with children of that age.[42] Dr Narayanan did not mention a lump on KLD's forehead as had been noted by her biological mother.[43]

When asked why the children were in care, KLD's biological father confirmed they had made some mistakes in the past.

Dr Narayanan indicated KLD's condition did not fit with a toddler's usual presentation nor was it consistent with the history they had from either sets of parents. He noted all parents seemed to be very concerned.

Ms Bassett attended at KRH with Ms Antonelli due to her previous interaction with the families. Ms Antonelli related to the hospital staff KLD's earlier runny nose, but on

[41] Ex 1, tab 14
[42] t 16.01.17, p229
[43] Ex 1, tab 14

checking it was apparent it had been some weeks earlier and she had not been to a doctor recently. There was some concern with KLD's foster mother due to her advanced pregnancy and distress.

DCP made arrangements for KLD's biological parents to travel to Perth to be with KLD in PMH. It was agreed KLD would travel without her parents due to her biological mother's reluctance to fly without her partner. They followed the next day after flights and accommodation were arranged by DCP.

Dr Narayanan and the other medical staff considered the benefits of a CT scan to look for a head injury but decided KLD was too unstable for them to risk the procedure. Their focus was to stabilise her as quickly as possible so she could be appropriately transferred to PMH via the RFDS.

In his referral letter Dr Brannigan advised PMH that KLD had arrived in the ED at KRH in full respiratory arrest and that;

"• Her pre-hospital downtime was approximately 20-30 minutes.
- Rhythm on presentation was asystole.
- She had no respiratory effort and was GCS 3 with fixed dilated pupils.

- She was intubated (initially with a size 3.5 ETT, grade 1 view, ++ vomitus and secretions in oropharynx) and ventilated, CPR commenced, IO access gained.
- 2 x 1.2ml (1:10000) adrenalin plus 200mcg atropine were given, and a 200ml NS bolus
- ROSC was detected by ETCO2 capnography and confirmed with pulse check about ten minutes after ED arrival.
- NGT inserted, stomach decompressed.
- Peripheral venous access attempts initially failed, second IO placed.
- Peripheral IVCs x2 placed. iA line placed right radial.
- Blood cultures sent.
- Dopamine infusion.
- IDC-no urine drained initially.
- IV ceftriaxone 100mg and vancomycin 150mg IV given.
- Oral ETT replaced with size 4 nasal ETT tied at 14."[44]

He advised KLD remained unresponsive with fixed dilated pupils, was requiring no sedation or paralysis and the neonatologist at KRH had been involved. He went on to explain the little social background they had that KLD had just returned from a supervised visit with her biological parents, may have had a respiratory tract infection in the preceding week, and that she had been quiet and lethargic earlier that day. Her urine had been noted as very dark and KRH's working diagnosis was sepsis or an acute viral

[44] Ex 1, tab 19

myocarditis compounded by dehydration leading to the cardiorespiratory arrest, however, the precise aetiology was unclear. He indicated the KRH neonatologist had discussed KLD with the receiving physicians at PMH. He clarified they did not suspect a toxicological cause via collapse and provided all notes and pathology they had to date with respect to KLD.[45]

ROYAL FLYING DOCTOR SERVICE

KLD was transported to PMH with the RFDS without a relative escort. Her vital signs were recorded from 9.10 pm on 16 August 2012. Her oxygen saturations remained between 70-85% and could not be improved with hand ventilation. Her condition was stable and unchanging, but of great concern.[46] She was handed to PMH at 11.37 pm.

PRINCESS MARGARET HOSPITAL

The PMH records KLD as admitted to the paediatric intensive care unit at 00.31 am on 17 August 2012.

The history provided by KLD's foster mother during the course of the inquest as to KLD's fall from a couch, immediately preceding a fit-like movement and the cessation of breathing was not relayed to anyone at the time of the event.

[45] Ex 1, tab 19
[46] Ex 1, tab 20

As far as the treating clinicians were concerned there was no history provided other than KLD had been unresponsive for about 20 minutes prior to her arriving in KRH. It was noted she had just returned from a visit with her biological parents and that she had been sleepy. Her foster mother had commented she thought KLD had held her breath and not recovered.

The clinicians were advised KLD's biological parents had reported she was drowsy during the supervised visit and disinterested in food, although she had eaten a small amount. She had refused to play and not allowed her mother to play with her hair. There is a comment in the PMH report that KLD's biological parents had noted bruises on KLD before, including bilateral black eyes and bruising to her cheeks.[47] I can find no reference to bilateral black eyes in either the DCP records or the statements of either of KLD's biological parents. I assume the cheek bruising to be the cheek pinches referred to in evidence.[48]

Clinicians from PMH held a teleconference with Ms Bassett, Kalgoorlie DCP, on 17 August 2012 in an effort to fully understand KLD's history.

Dr Houliston, Paediatric Consultant, Child Protection Unit at PMH reported KLD was admitted to the paediatric intensive unit in a critical condition and that CT scans

[47] Ex 1, tab 22
[48] t 13.01.17, p149

performed indicated the presence of an intracranial bleed and severe swelling of the brain. It was not considered surgery would be of assistance. She was assessed as brain dead and repeat testing confirmed that diagnosis on the afternoon on 18 August 2012.

KLD was maintained on life support for 5 days to enable thorough examination. Those investigations had included a full skeletal scan as well as an ophthalmic examination on 17 August 2012 and further neurosurgical examination.

A decision was made to withdraw all treatment from KLD on 21 August 2012 and late in the evening on 22 August 2012 she was confirmed to be deceased.

Clinical Examination

KLD was found to have extensive bruising and abrasions over her ears, face, scalp and neck. There was also a large abrasion to her chest and some bruising. Her back showed pigmented lesions which were thought to be mongolian blue spots. She had areas of scarring on her right arm and abdomen, right leg and left leg.[49]

She also had numerous puncture wounds consistent with her medical resuscitation.[50]

[49] t 17.01.17, p269
[50] Ex 1, tab 22

Ophthalmic Examination

Examination of KLD's eyes by Dr Geoffrey Lam on 17 August 2012 revealed extensive retinal haemorrhage of different types and at different depth within the retina. Dr Lam described both superficial flame haemorrhages and deeper blot and dot type haemorrhages in both KLD's right and left eye. Retinoschisis was also exhibited in her left eye with a clear retinal fold. Dr Lam considered a range of diagnoses for KLD's retinal haemorrhages, but came to the conclusion some form of acceleration-deceleration or shearing force injury was the most likely.[51]

One of the registrars caring for KLD in PMH had queried a possibility of Terson's syndrome in the hospital notes. Dr Lam did not agree with that notation and indicated Terson's had not been reported in children. He agreed Terson's syndrome in adults was attributed to a very acute, very rapid change in intracranial pressure, and that if there was acute increase in cerebral pressure it may be possible in children but had never been reported. He did not believe the imaging reflected Terson's syndrome.[52]

Dr Lam similarly agreed it was possible blood could have slipped between the optic nerve sheath, then the optic nerve and into the retina around the optic nerve by way of venous congestion but again disagreed that was a likely explanation

[51] Ex 10.1 & 10.2, t 20.01.17, p435-436
[52] t 20.01.17, p440

for the distribution of haemorrhages seen in the PMH slides for KLD.[53] There is no question the technology available to PMH is vastly in advance of that available to the State forensic pathologists but forensic neuropathology has the advantage of actually being in a position to examine the relevant tissues.[54]

Radiology

Preliminary X-rays taken at KRH on 16 August 2012 and at PMH on 17 August 2012 were reviewed by Dr Fiona Bettenay, consultant paediatric radiologist, as well as those taken later at PMH.

A CT scan of KLD's head on 17 August 2012 recorded moderate cerebral oedema with parafalcine and tentorium subdural haemorrhage and subarachnoid haemorrhage in keeping with traumatic brain injury. There was incomplete enfacement of the lateral ventricles and paramesencephalic cisterns. At that stage there was no cerebellar tonsillar herniation or medullary compression seen with advanced coning. There were no skull fractures.

In evidence Dr Bettenay discussed the brain injuries she observed on radiology from 17 August 2012 and said they were consistent with the primary mechanism of injury being trauma, by that she meant non-accidental injury.[55] The

[53] t 20.01.17, p441-442
[54] t 20.01.17, p444-445
[55] t 17.01.17, p253

subdural haemorrhage was thin, extensive and extended into the parafalcine region and over the tentorium, and subarachnoid haemorrhage. It was high density blood which indicated it was from a few hours to a few days only in age, and the parafalcine subdurals in particular were seen in shearing type injuries.[56]

Dr Bettenay agreed the crux of the injuries from a causal perspective was: did KLD's collapse give rise to the observed injuries or did the injuries predate KLD's collapse. This was of especial significance when attempting to correlate the clinical evidence with the later neuropathology. From Dr Bettenay's perspective (radiological) the evidence was that the brain in this case was profoundly affected by trauma and it was that trauma which resulted in the collapse.[57]

Dr Bettenay also commented on the appearance of tiny foci suggestive of petechiae at the grey and white junction in the parenchyma being evidence of significant head injury, again of a major shearing force injury, and rapid coning.[58] Dr Bettenay did not expect that, at the time of that CT scan on 17 August 2012, KLD's brain would have been as swollen as it was by the time of her post mortem examination, or the later CT scans (20 August) when the cranial sutures were very pronounced. To Dr Bettenay that

[56] t 17.01.17, p255
[57] t 17.01.17, p256–7
[58] t 17.01.17, p259–260

indicated a major arrest followed by brain swelling. That is a brain injury followed by a cardiorespiratory arrest, with the primary insult being a head injury which gave rise to a cardiorespiratory arrest and so a secondary insult.[59]

Finally, it was Dr Bettenay's opinion that *"almost every paediatric radiologist who looks at this head"* (the radiology of KLD's head) *"would suggest the primary mechanism of injury is trauma."*[60] She explained that view in some detail in evidence.

Dr Bettenay agreed there is literature on short falls resulting in death but pointed out they are so rare they are documented, and in Australia the recorded mortality rate from low height falls in paediatric patients is less than one in a million.[61]

Dr Bettenay also discussed the possibility of a spectrum of abnormal responses to head trauma called second impact syndrome, but again did not feel the CT evidence, while not clear, necessarily fitted that situation. The history of KLD's changing demeanour over the three to four weeks before her collapse seemed to suggest minor episodes of trauma, to which she would have needed to respond abnormally, and very significantly to a final, apparently minor, head trauma, when taking into account the apparently different ages in

[59] t 17.01.17, p261
[60] t 17.01.17, p253
[61] t 17.01.17, p263

KLD's skeletal injuries and her change in presentation, for second impact syndrome to apply.[62]

A CT scan of KLD's cervical spine on 17 August 2012 was reported as normal while that of her abdomen and pelvis found free intra-abdominal fluid with the impression of mesenteric and bowel oedema. Her lung base showed bilateral perihilar infiltrates possibly reflecting oedema/congestion, but no pleural effusions.

The abdominal ultrasound of the same date showed no major visceral injury. The chest X-ray showed a non-specific finding of bilateral pulmonary infiltrates confirmed by the later CT.

Skeletal Survey

A skeletal survey was undertaken on 20 August 2012 and reported on by Dr Bettenay. This showed irregularity of the costochondral junction in the ribs which can be incurred through cardiac massage. There were no posterior rib fractures or healing fractures anywhere else.

KLD's right upper limb indicated a periosteal reaction along the distal right humeral metadiaphysis which Dr Bettenay assessed as post traumatic and relating to an injury a few weeks earlier. There was also a well-defined periosteal reaction along the medial left humeral metadiaphysis and

[62] t 17.01.17, p263–4

posteriorly. This also indicated an earlier subacute injury, about the same age as that in the right arm.[63]

There could be a range of possibilities for these bilateral arm injuries but the most likely is a forceful grip on each arm in the process of lifting KLD. It would be possible for it to be inflicted by an older child.[64]

Dr Bettenay observed a soft tissue swelling around the deceased's knee, which could relate to medical intervention, and noted the prior right knee injury consistent with her trip to KRH on 24 June 2012. There was an area of injury on the right proximal tibial metaphysis, possibly a healing fracture which Dr Bettenay assessed as a different age from the KRH injury and those in her upper limbs.[65] The right tibia fracture could indicate an injury consistent with the history given by KLD's biological parents and Ms Stone of KLD appearing quieter and less active than usual from the beginning of August 2012.[66]

In evidence Dr Bettenay compared the skull skeletal survey of the 17 August 2012 with that of 20 August 2012 and indicated there was universal widening of the cranial sutures from 17-20 August 2012 which was indicative of

[63] t 17.01.17, p249
[64] t 17.01.17, p250
[65] t 17.01.17, p246, 250–1 & Ex 3, p247–8
[66] t 17.01.17, p252, 263

further severe brain swelling and raised intracranial pressure. There was no skull fracture observable.[67]

Blood Investigations

KLD's coagulation profile was essentially normal, but her full blood count showed low haemoglobin, possibly due to an intracranial bleed, and a low white cell count in keeping with her history of a respiratory infection (runny nose). There was a normal platelet count. The C-reactive protein serum was normal and the liver function tests indicated mildly raised to normal ALT, with low albumen and total protein likely to be diet related. Her lipase and amylase were normal, urea and electrolytes normal, calcium, magnesium phosphate normal, with a low vitamin D possibly secondary to inadequate sun exposure.

CLINICAL VIEW

In the view of the clinicians dealing with KLD at PMH, KLD presented to PMH in cardiorespiratory arrest with hypoxia so severe it was incompatible with life despite intense medical intervention. It was the clinicians' view KLD's head injuries were the result of an inflicted injury with some of the other earlier injuries likely to be inflicted, as in the bony healing injuries and those to her ears. In addition the clinicians believed the subdural haemorrhage, subarachnoid haemorrhage and the external bruising and

[67] t 17.01.17, p260

soft tissue injuries indicated her injuries were *"highly likely to be the result of inflicted injury".*[68]

An overview was provided by Dr Alan Duncan, now retired, who had been a Director of the Paediatric Intensive Care at PMH, prior to which he was the Director, Paediatrics Intensive Care at the Royal Children's Hospital Melbourne. At the time Dr Duncan reviewed the case he had all the clinical opinions, as well as a copy of the post mortem report and neuropathology and toxicology. Dr Duncan gave evidence that on the balance of probabilities it was his opinion the constellation of a poor home environment, regression of developmental milestones, the lack of a reliable history, the multiple bruising and abrasions and multiple bony injuries of the type found in KLD were indicative of inflicted or non-accidental injury.[69]

Following a discussion with the neuropathologist, Dr Vicki Fabian, Dr Duncan provided a follow up report indicating there were possible alternative considerations to inflicted injury being the direct cause of KLD's death. However, in evidence he was still very much of the view the complete picture was strongly suggestive of inflicted injury by way of "*shaken baby"* with respect to KLD's injuries.[70]

[68] t 17.01.17, p267
[69] Ex 1, tab 26
[70] t 13.01.17, p119

POST MORTEM EXAMINATION

The post mortem examination of KLD was undertaken by Dr D Moss, Forensic Pathologist, PathWest Laboratory of Medicine WA, QEII WA, on 25 August 2012.

Dr Moss explained the post mortem examination revealed a swollen brain with a patchy thin film subdural haemorrhage. The brain, spinal cord and column and eyes were retained for formal neuropathological examination.

In evidence Dr Moss commented the number of healing abrasions and bruising and soft tissue injuries were unusually high in number for a child of KLD's age. He found her internal organs to be normally developed with oedema of the lungs.[71]

Microscopic examination showed no evidence of significant inflammatory changes within the heart, though there was evidence of bronchopneumonia, frequently seen after a patient has been maintained on life-support, as well as an acute inflammatory exudate within her bronchioles.[72] All remaining major organs were unremarkable. Sections from the bruises showed areas of fresh appearing haemorrhage but without significant numbers of macrophages and a minimal haemosiderin deposit.

[71] t 18.01.17, p374–5
[72] t 18.01.17, p361–2

Dr Moss confirmed the apparently healing injury to the costochondral junctions of the ribs and the right distal humerus. Those on the left distal humerus also showed evidence of healing, as did the right proximal tibia.

Microbiology showed enterovirus/rhinovirus within the heart, large bowel and small bowel, while virology testing was unremarkable. Dr Moss did not consider these tests to be particularly significant towards a cause of death for KLD. There was nothing in the toxicology of concern and dental examination showed normal dentition with no sign of oral trauma.

An injury on the left lower back was examined by a forensic odontologist, Dr Steven Knott, and found to be inconsistent with a bite mark.[73]

Dr Moss indicated that in his view it was clear KLD's death resulted from complications of a prolonged cardiac arrest, but the underlying aetiology of the arrest had not been identified despite thorough post mortem examination and extensive ancillary testing. While Dr Moss agreed there was evidence of injury in KLD, both recent and older bony injury, there was no evidence of significant injury at the time of her arrest to conclusively determine a cause of death beyond that of hypoxic ischaemic encephalopathy following unexplained cardiorespiratory arrest.

[73] t 18.01.17, p362

While Dr Moss had originally included bronchopneumonia as complicating the hypoxic ischaemic encephalopathy he was content to agree with the clinicians the bronchopneumonia could have arisen solely as the result of KLD's time on ventilation and did not necessarily reflect any hangover from her preceding respiratory illness.[74]

NEUROPATHOLOGY

Dr Vicki Fabian, Neuropathologist, undertook extensive neuropathological examination which at the macroscopic level showed cerebral swelling with features of *"ventilator brain"*.[75] The brain architecture was essentially normal.[76] There was patchy subarachnoid haemorrhage over the lateral aspects of the left frontal lobe and a parasagittal distribution over both cerebral hemispheres. In evidence Dr Fabian emphasised how thin this subdural haemorrhage was and she disagreed with the clinicians this was evidence of shearing injury.[77]

In Dr Fabian's view that very thin haemorrhage, which was a surface haemorrhage and not a contusion or laceration,[78] could be a reperfusion injury or, accepting some history of a short fall and haemorrhages of the left eye, the result of a short fall, but not one which would generally be called a

[74] t 18.01.17, p362
[75] t 17.01.17, p296 & 299
[76] t 17.01.17, p289
[77] t 17.01.17, 290, 291, 295, 313, 316, 321, 324, 327
[78] t 17.01.17, p295

traumatic brain injury.[79] Dr Fabian could find no reference in the hospital CT scans of blood in the lateral ventricles. She found it on neuropathological examination and believes the fact it was there after resuscitation supports the fact it was reperfusion blood, rather than a traumatic brain injury. Dr Fabian's examination of KLD's spinal column also supported a reperfusion injury rather than a traumatic injury.[80] If there had been an acceleration-deceleration injury Dr Fabian would have expected histology and microscopy to reflect traumatic injury, and for there to be relevant amyloid precursor protein (APP) staining which there was not.[81]

The only spinal injury appeared at the T3 and T4 levels of the spine and this was consistent with watershed, or border zone injury, on reperfusion following global perfusion failure of the brain and spinal cord, consistent with resuscitation.[82]

Microscopic examination of the brain and spinal cord showed multi-focal hypereosinophilia of the neurones with loss of nuclear detail. These features are in keeping with recent hypoxic ischaemic encephalopathy of approximately 4-6 hours duration prior to brain death/global perfusion failure of the brain. There were also fragments of the cerebellum seen within the subarachnoid space, with the

[79] t 17.01.17, p292, 295, 299, 302
[80] t 17.01.17, p305/6, 323
[81] t 17.01.17, p310-316, 323, 332
[82] t 17.01.17, p309

distal medulla resection margin in keeping with ventilator brain.[83]

In evidence, Dr Fabian discussed the haemorrhage at the T3/T4 level which she described as being a water shed or border zone finding indicating there had been a severe loss of blood pressure and that on restored perfusion, haemorrhage was seen at this level as the two bloods met. Dr Fabian indicated this was a haemorrhage seen as the result of the restoration of perfusion and did not relate to traumatic injury. The restoration of perfusion occurred at KRH. There were no haemorrhages consistent with traumatic injury which one would expect to see had there been severe acceleration-deceleration type injuries in the brain or spinal column.[84]

At post mortem examination Dr Fabian was unable to see the extent of retinal haemorrhaging described by Dr Lam on 17 August 2012 in her initial eye examination. Dr Fabian only observed recent haemorrhage in the periorbital adipose tissue of the left eye and noted recent circumferential subdural haemorrhage around the optic nerve in the left eye. She did not observe any retinal haemorrhages. It was her belief that her observations in the left eye supported a fall injury.[85]

[83] t 17.01.17, p325
[84] t 17.01.17, p292, 321-323
[85] t 17.01.17, p339

Dr Fabian's right eye examination showed recent circumferential subdural and subarachnoid haemorrhage extending along the entire length of the optic nerve with a single focus recent haemorrhage in the ganglion cell layer of the retina. In evidence Dr Fabian indicated she believed the blood observed in the sheath of the optic nerve related to drainage from the subdural haemorrhage along the optic nerve rather than a vitreous traction injury in the eye.[86]

Dr Fabian had noted the entry in the hospital notes which queried Terson's syndrome and believed that, if correct, supported her view a short fall caused a rapid catastrophic increase in intracranial pressure which precipitated the cardiorespiratory arrest which then caused further cerebral swelling, then coning and brain death.[87]

Dr Fabian also pointed out that at KLD's age of 21 months, her brain was closer to that of an adult than an infant of under 12 months of age.[88]

Following the evidence given at inquest by Dr Lam, Dr Fabian re-examined KLD's left eye histology by taking additional levels from the blocks. She then provided a supplementary report in which she noted a few patchy recent retinal haemorrhages, not wide spread in neuropathological terms and not extending to the periphery

[86] t 17.01.17, p339
[87] t 17.01.17, p292-293 & 300
[88] t 17.01.17, p295

of the eye or the ora serrata. They were all posterior.[89] Dr Fabian concluded that additional sectioning did disclose further haemorrhages, but that the distribution and appearances of those haemorrhages did not alter her view the injuries were more consistent with a (short) fall than indicative of a serious deceleration-acceleration injury,[90] such as that described by Dr Lam from the very sophisticated imaging provided to the court of the eyes on 17 August 2012.[91]

Further APP staining did not reveal axonal nerve damage consistent with traumatic or non-accidental, inflicted injury (in this case acceleration-deceleration injury). As a result of her examination Dr Fabian could not support the clinicians' diagnosis of an inflicted traumatic brain injury as being the cause of KLD's arrest and demise.

In evidence Dr Fabian indicated she was of the belief the cause of death was cerebral swelling. This was undisputed from both the clinicians and the post mortem perspective. However, the mechanism by which that occurred is in sharp conflict between the clinical and neuropathological findings.

Dr Fabian was of the view there had been some soft or minor trauma which had caused a rare, but recorded, very rapid increase in brain swelling which had caused the

[89] Email communication provided by OSC to all parties 17 May 2017
[90] t 17.01.17, p335, 339
[91] t 17.01.17, p340

cardiac arrest as observed by KLD's carer foster mother at approximately 1.30 pm on 16 August 2012. This cardiac arrest resulted in ischemia which then progressed to more severe brain swelling and the secondary insult which resulted in KLD's death.[92] This is in contrast to the clinicians' view there was traumatic brain injury which caused the cardiac arrest which then produced the brain swelling in its entirety. Both the clinicians and Dr Fabian confirm the medulla was still functioning at some level, as per the staining observed by Dr Fabian in the brain stem as supporting the hypothesis there was progressive hypoxic ischaemic encephalopathy.[93]

Limited metabolic screening was reviewed by reference to KLD's birth Guthrie card which excluded a number of metabolic conditions as occurring in KLD.[94] There is, however, the possibility of a rare condition not covered by screening at birth.[95]

Essentially the outcome of the clinicians' view and the post mortem examinations confirmed hypoxic ischaemic encephalopathy with different mechanisms for the initiating cardiorespiratory arrest. The clinicians believed inflicted traumatic brain injury caused the cardiac arrest, while neuropathology indicated that a soft or very mildly traumatic injury may have caused a sudden catastrophic

[92] t 17.01.17, p327/8
[93] t 17.01.17, p316
[94] t 17.01.17, p341
[95] t 18.01.17, p396/7

increase in brain pressure which caused the cardiorespiratory arrest which then resulted in the hypoxic ischaemic encephalopathy following down time from that arrest.

The neuropathological examination and explanation, although rare, is supported in the literature and while supporting some form of trauma, does not support a violent injury of the sort which would necessarily cause concern to DCP as to caring capabilities.[96]

This is completely separate from the issue of the skeletal injuries, and soft tissue bruising and abrasions, all of which were healing and imply ongoing soft trauma or accidental injuries of different ages.[97]

The overview of Forensic Pathologist, Dr Sarah Parsons, essentially agreed the evidence she had reviewed indicated the cause of KLD's death was hypoxic brain injury and could not exclude traumatic brain injury. She did not suggest that was the only explanation.

"The deceased had evidence of previous injuries to long bones which is suggestive of previous episodes of inflicted trauma. There are no bony injuries that have a contemporaneous relationship with the intracranial findings.

[96] t 17.01.17, p318
[97] t 18.01.17, p366

The clinical and radiological opinions I have been provided with have stated that the injuries are highly likely to be as a result of inflicted injuries. There is nothing in the materials I have reviewed that are at odds with these opinions.

Whilst definitive cause of the cardiorespiratory arrest in this child is not clear, given the constellations of injuries in this infant it is my opinion that non-accidental injury cannot be excluded to be the cause of this child's death."[98]

However, in evidence Dr Parsons agreed there was no reason for interchanging the "*inflicted injury*" with the "*non-accidental injury*" and she was not there distinguishing between inflicted and accidental trauma, rather she was referring to the fact of trauma, without specifying whether it was inflicted or non-accidental. Inflicted trauma can still be accidental, in that it was not intended.[99]

CAUSE AND MANNER OF DEATH

Having heard the evidence of the clinicians, including ophthalmology, and the evidence from all the post mortem examinations, particularly neuropathology, it is almost impossible to reconcile the views which appear to be diametrically opposed. Certainly the evidence from radiology, supports an ongoing level of traumatic injuries to KLD over a reasonably prolonged period of time. That

[98] Ex 1, tab 32
[99] t 18.01.17, p395-396

appears to be consistent with the history provided by both the biological parents and, to some extent, the DCP family resource workers of a change in KLD's demeanour noted from the beginning of August 2012. The difficulty is there were periods of time when the biological parents did not attend contact visits and so there were no independent observations of KLD's demeanour at those times.

The evidence of KLD's foster parents was that she had always been quieter than their other children at a comparable age. However, the evidence of her progress prior to June 2012 seems to be that of a normally developing child who responded positively to both her biological parents, her foster parents and workers from DCP. There were no concerns with her presentation when she was in foster care with the Joondalup carers or first arrived in Kalgoorlie and had appropriate case management.

The DCP workers taking KLD to supervised access visits, when they occurred, noted her to be reactive, positive and bouncy. There seems to have been a gradual decline in her demeanour and Ms Stone confirmed there was a period of time when KLD appeared to have a cold and her nose was scabby and runny which seemed to last for a long time. It would seem to be probably in about June/July 2012 this occurred and we know KLD was taken to hospital at the end of June for a problem with her knee when she had fallen. There is also the evidence of her uncle that she had

appeared to be restrained at some stage but he could not provide a time frame.[100] Her foster mother explained that had been with soft items to prevent KLD from picking at her scabby nose and ears.[101] However, none of those appear to reflect serious inflicted traumatic injury, rather a series of traumas about which it is not possible to be clear as to their origin.

There is also the fact KLD was the youngest child of four in a house hold with a heavily pregnant foster mother and some of her care was being undertaken by an 11 year old girl. It would appear to be possible that, as the youngest child, KLD was picked upon by others in the household. I note her foster mother was extremely protective of the role of the other children in KLD's care.[102]

The bony injuries observed by the clinicians and at post mortem were not of such severity in themselves as to cause her death and appeared to have been caused at different times and be healing. The fact those were not picked up and treated at the time they occurred is a cause for concern and could well relate to the decline in KLD's demeanour.

If I accept the history and evidence indicate KLD suffered trauma in the last two months of her life, which I do, this would support ongoing inflicted trauma, but not necessarily

[100] t 12.01.17, p68
[101] t 13.01.17, p178
[102] t 13.01.17, p180

non-accidental, in the two months preceding her death. That does seem to be most consistent with the history as far as I can deduce it from the evidence and also the clinical and post mortem evidence.

This does not mean an acceptance that ongoing accidental trauma to the level observable in the history and post mortem findings of KLD, without medical intervention, is acceptable in a child being cared for by anyone. However, does not go so far as to say the evidence is unequivocal that KLD was subjected to an inflicted, non-accidental trauma on 16 August 2012 which directly caused her death.

In coming to this conclusion I refer to the numerous articles with which I was provided in the course of the inquest by both clinicians, pathologists and counsel assisting. I have reviewed all of those and would have to say I find the summary of the current situation, from a medico legal perspective, in the article of the University of Michigan Law School, 2012, *"Shaken Baby Syndrome, Abusive Head Trauma, and Actual Innocence: Getting it Right"* to have been the most useful in trying to put together the history for KLD and the differences in clinical and forensic neuropathological input. [103]

I take from the opening summary of that article this quote *"while we must do everything in our power to protect*

[103] University of Michigan Law School - University of Michigan Law School Scholarship Repository Volume 12, No.2, p209-312; Ex 9

children, we must refrain from evoking abuse as a default diagnosis for medical findings that are complex, poorly understood, and have a wide range of causes, some doubtlessly unknown."[104]

Based on the history as we have it, which admittedly is not complete, and the clinical findings from 16-20 August 2012, and the post mortem examination results, I find the most likely explanation for KLD's cardiorespiratory arrest was a combination of *"soft"* or accidental traumatic incidents which on 16 August 2012, at sometime between 1-2pm, were exacerbated by a short fall with a catastrophic response by KLD's system, which by this point was seriously taxed.

It seems most likely that short fall resulted in sudden increased brain pressure which led to cardiorespiratory arrest as observed by KLD's foster mother when she picked her up after her fall to the ground. That cardiorespiratory arrest then caused hypoxic injury, which by the time it was reversed in KRH by reperfusion was irredeemable. Despite the best of medical input KLD did not survive and was finally pronounced deceased on 22 August 2012 following a period of life support so family members could gather for her farewell.

[104] University of Michigan Law School - University of Michigan Law School Scholarship Repository Volume 12, No.2, p209-312; Ex 9

I accept short falls resulting in such catastrophic responses are rare in the literature, but the fact they are there and recorded, persuades me it is not an unknown outcome which I should dismiss out of hand.

I therefore find the cause of KLD's death was undoubtedly hypoxic ischaemic encephalopathy.

However, in view of the conflicting evidence as to the precise timing and mechanism of the cardiorespiratory arrest, I make an Open Finding as to her manner of death.

CONCLUSION

I am satisfied KLD was a 21 month old female Aboriginal child in the care of DCP through its Kalgoorlie office in August 2012 when she died.

I am aware of the reasons for KLD and her brother being taken into care and have no difficulty with the fact that was an appropriate course of action for DCP to take. While it is clear KLD's biological parents loved her there was a considerable issue with their ability to care for her.

KLD and her brother had been in the care of DCP since September 2011 and originally stayed with carers in Joondalup with supervised access to their biological parents when they chose to attend. There is no dispute that when KLD's biological parents were observed supervising the

children there were no issues with their parenting or care of the children.

KLD initially responded very well while in the care of DCP, but the difficulties with access visits and her biological parents meant it was desirable KLD and her brother be moved to Kalgoorlie where her biological parents had supportive family.

In an effort to accommodate the family unit DCP attempted to find carers in the Kalgoorlie area to care for the two children. They were unsuccessful in this and eventually relative carers in the form of KLD's biological mother's niece and her partner were proposed as suitable carers. DCP accepted this family as a suitable relative carer situation for KLD and she was moved, with her brother, to Kalgoorlie in March 2012. The foster carers (relative carers) had two small children of their own and there was no concern with their care of KLD and her brother. KLD's foster mother became pregnant and as the pregnancy progressed it is apparent she had some difficulty dealing with so many young children, despite the assistance of her own mother.

I am satisfied at some stage KLD contracted a respiratory infection for which she was taken to the doctor and appears to have taken a long time to recover, with some evidence of a scabby runny nose for a prolonged period of time. It would appear to be around about this time the care of KLD,

as the smallest child in the house hold, became less than optimal. She suffered some incidents of injury, probably accidental, which appear to have gone unnoticed. Her progress stagnated. Rather than progressing as a lively, healthy toddler, she began to show signs of withdrawal which were not picked up or acted upon. This was possibly contributed to by the fact there was a period of time when compliance with supervised contact visits was minimal by her biological parents and so the regular review of KLD by DCP family resource workers was stalled. When those visits were reinitiated the fact KLD seemed quieter was not immediately observed as significant.

It is significant to me that KLD's apparent withdrawal also corresponded to the time frame over which the DCP Kalgoorlie office became solely responsible for KLD and her brother, but the children had no case worker.

I am satisfied that by early August 2012 KLD was showing signs of withdrawal which her biological parents noted, but did not consider to be of as much concern as later was proved to be warranted. They were reassured by the fact they believed she was in care and DCP should be aware of any problems.

I am satisfied that by mid-August 2012 KLD was in a withdrawn state and possibly suffering physical and physiological compromise.

On 16 August 2012 following a supervised access visit at which KLD was noticeably quiet and withdrawn, but not exhibiting overt symptoms, KLD was returned to her foster carers home in a drowsy condition.

At some stage following her return home she was placed on the couch and suffered a fall, the exact parameters of which remain a little unclear.

KLD called out to her foster mother, who found her on the ground and picked her up. Once her foster mother had picked her up, KLD suffered a "*fit*" with her eyes rolling back in her head, and I suspect that was the time of her cardiorespiratory arrest. KLD's foster mother did not have a telephone and was not in a position to ring for help. She gathered the other children, all of whom were 11 years or younger, and drove KLD to hospital as quickly as she could.

KLD remained in cardiorespiratory arrest until she was stabilised at KRH. By that time her down time had been at least 30 minutes and she had suffered irreparable brain damage. Despite transfer by RFDS and the best of care at PMH the prognosis for KLD could not be improved and while she was declared brain dead following brain function tests on 17 & 18 August 2012, she was maintained on life support until family gathered and could say their goodbyes. She was finally declared deceased on 22 August 2012.

COMMENTS ON SUPERVISION, TREATMENT AND CARE OF KLD

I have already commented on the fact that the reasons for DCP placing KLD and her brother into care were appropriate. The history of DCP reaching that decision is well documented in their files.

The initial placement of KLD and her brother with foster carers in Joondalup, despite the fact they were non-Aboriginal carers, was an appropriate placement and KLD's biological parents were very happy with that placement. I note KLD's brother has been returned to that care and continues to do very well.

DCP, at all times, was working with KLD's biological parents for reunification of the family. The fact it was only a two year placement was done with the hope KLD's biological parents would eventually be in a position to resume their care of KLD and her brother. It was clear in evidence the children were well loved by their biological parents. Unfortunately, their biological parents were fundamentally unable to care for the two children. Despite counselling and numerous attempted interventions, there remained difficulty with the biological parents' ability to consistently look after KLD and her brother. This was reflected by the number of times supervised access visits had to be cancelled because their parents could not attend.

The move of the children to Kalgoorlie from Joondalup was an effort to enable continued appropriate contact between KLD and her biological parents. On the occasions it occurred it was clearly successful, however, there was difficulty with consistency.

The fact KLD and her brother, when still part of the Joondalup DCP case load, had two part time case managers, the equivalent of a full time case manager, but on moving to Kalgoorlie effectively had no case manager while placed on the monitored list in the control of a team leader, is clearly not appropriate supervision, treatment and care.

I emphasis this is not a reflection on the individuals. I am satisfied Ms Antonelli, in view of the fact she was not the children's case manager, did her very best to assist both biological parents and carer parents. This was simply not enough.

It was evident from both the input of the biological parents and the foster parents that their access to appropriate DCP intervention at times it was necessary was lacking. Due to the fact the children had no case manager there was no one to ensure ongoing coordination of difficulties with the children. This is emphasised by the fact the resource worker contact visit feedback notes to which I had access, were never read by a case manager, so the fact there was a

decline in KLD's demeanour, although noted by the resource worker on the feedback notices, was never taken into account, or investigated.

Ms Bassett, as a team leader, indicated the situation now is that the team leader for children on the monitored list does read the contact feedback. A child in the care of DCP, however, should not have to rely on the input of parents from whom she was removed to ensure proper care.

I find it extremely distressing the resource situation in Kalgoorlie DCP in 2012 was such that there were 100 children on the monitored list, presumably all receiving reduced care on the part of DCP as observed in this case.

My finding that it is likely KLD's death was the result of a culmination of traumatic injuries which led to a final systems overload for which her system was unable to compensate, really reflects a lack of ongoing supervision, treatment and care, more than one isolated inflicted traumatic injury would have.

In my view both KLD and her brother should have been assessed by the consultant paediatricians at KRH on their arrival in Kalgoorlie to provide a base line assessment of their progress and development as of March 2012. That assessment would then have provided a basis by which a case manager could follow the feedback information

provided by the family resource officer on contacts DCP had with the children. Had KLD's decline been noted before 16 August 2012 it would have been appropriate for the case manager to have KLD reviewed by KRH, with a view to ascertaining her apparent withdrawals, and re-assess her living arrangements. Intervention of some description was necessary. KLD and her brother should also have been regularly observed by a care worker familiar with them.

This coupled with the foster mother's advancing pregnancy and need to rely on other assistance while caring for KLD should have seen a situation where there was more input from DCP as to appropriate supervision, treatment and care of the children and to provide respite to the carer family. Children will experience traumatic injury from time to time, but adequate supervision and care should see appropriate interventions and treatment around those incidents which would ensure that a child's progress was not developmentally delayed, or even destroyed.

I appreciate there was little cause for concern on behalf of the DCP with the contact between the children and the biological parents and the carer parents in the normal course of events. It was clear the children were well loved, but with appropriate review it would have become increasingly clear that KLD was not being cared for or supervised appropriately.

Recommendation No.1

I recommend that on the transfer of children in care from one location and set of carers to another, there be appropriate assessment by consultant paediatricians in the new location to record a child's welfare and progress. This is on top of and in addition to their annual assessments.

Recommendation No.2

I recommend all children transferred from one location to another have a case worker. Only successful long term foster placements should be placed on a monitored list, after a suitable period of reasonable review.

Recommendation No.3

I recommend all contact of DCP workers with children in care be recorded and appropriately assessed in a group meeting to ensure there is adequate supervision of the care and treatment provided to children in departmental care.

Recommendation No.4

I recommend resourcing for the State Mortuary to be provided with a CT scanner. It would assist the forensic pathologists to have appropriate technology for their investigations and enable more compatibility of language between pathologists and clinicians. In evidence Dr Lam

INDICATED THE PMH CT SCANNER WAS STATE OF THE ART AND WOULD BE AVAILABLE ON OPENING OF THE NEW CHILDREN HOSPITAL, WHICH HOPED TO HAVE RAISED FUNDS BY THEN FOR NEW IMPROVED TECHNOLOGY IN THE FORM OF OPTICAL COHERENCE TOMOGRAPHY TO ASSIST PMH CLINICIANS WITH IMAGING.[105]

E F Vicker
Deputy State Coroner
30 June 2017

[105] t 20.01.17, p444-445