Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 1 /18

I, Sarah Helen Linton, Coroner, having investigated the death of ***KPLW*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***10 January 2018*** *find that the identity of the deceased person was* ***KPLW*** *and that death occurred on* ***29 March 2013*** *at* ***Northam Regional Hospital*** *as a result of* ***consistent with respiratory failure and acute pancreatitis in a young girl with cerebral palsy, seizure disorder and chronic respiratory problems*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisting the Coroner.
Ms J Rhodes (State Solicitor's Office) appearing on behalf of the Department of Communities (previously known as the Department of Child Protection and Family Support).
Ms A Barter (ALS) appearing on behalf of the family of the deceased

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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 referred to as KPLW.

INTRODUCTION

1. KPLW (the deceased) was born on 1 September 2005. She appeared healthy at birth and was discharged home from hospital to live with her biological parents and older sibling. There were no formal concerns raised about the deceased's health until 14 October 2004, when she was six weeks old. On that day she was taken by family to Peel Health Campus and then transferred to Princess Margaret Hospital (PMH). Extensive medical tests revealed an acquired brain injury and various other injuries to her body. Her family were unable to give an explanation as to how she had been injured. The nature of the injuries suggested the deceased had been violently shaken, often known as 'shaken baby syndrome'.

2. An investigation by the Child Protection Unit at PMH in conjunction with the Department for Child Protection and Family Support (the Department)[1] ensued. The investigation found the deceased had suffered substantiated physical harm. Given there were many people living in the household with the deceased, there were a number of people who had the opportunity to cause harm to the deceased. There was insufficient evidence to identify the person responsible for harming the deceased and no person was charged with a criminal offence in relation to the matter. However, the Department's investigation raised concerns that the deceased's parents may have been involved in causing harm to the deceased through rough handling and at the very least they had not been sufficiently protective of the deceased.[2]

3. The Department concluded that the deceased was in need of protection and care. A Protection and Care Order was granted by the Children's Court and the deceased was placed into the care of the Chief Executive Officer of the Department.

4. Due to the deceased's profound physical and cognitive disabilities it was highly likely that she would require high level 24-hour care for the rest of her life. The deceased initially had some placements with extended family before being placed at Lady Lawley Cottage while a suitable foster care placement was identified.[3] In June 2006 the deceased was placed with foster carers who were experienced in providing care to children with special needs.

5. The protection and care order was extended and a final order was granted on 10 November 2009, to remain in place until the deceased turned 18 years old (1 September 2023). This was supported by the deceased's biological mother and maternal grandmother, who had realistic concerns about their ability to provide care for the deceased given her complex medical needs.[4]

6. The deceased remained with her foster carers until she died on 29 March 2013 at the age of 7 years. Her death, although tragic for a person so young, was not unexpected given her serious health issues throughout her short life and appeared to arise from natural causes.

[1] As it was then known.
[2] Exhibit 3, Tab 24B.
[3] Exhibit 3, Tab 24B.
[4] Exhibit 3, Tab 24B.

7. As the deceased was under the care of the Department at the time of her death, 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.[5] I held an inquest at the Perth Coroner's Court on 10 January 2018.

8. The circumstances of the death were investigated by police. Significant material was provided by the Department as part of the investigation. At the conclusion of the investigation a comprehensive report of the death was prepared, which was tendered at the inquest.[6] The deceased's medical records were also tendered.[7]

9. The inquest focused primarily on the care and supervision provided to the deceased prior to her death by the foster carers arranged by the Department. To assist in that regard, Mr Andrew Geddes from the Department (now known as the Department of Communities), gave evidence at the inquest. Evidence was also heard from an expert paediatrician who reviewed the deceased's records and provided an opinion on the care, treatment and supervision provided to the deceased.

10. The evidence before me showed that the deceased was cared for by the same foster carers from 2006 until her death. Her foster carers were committed to providing a safe, supportive and loving environment for the deceased throughout her relatively short life. They were still caring for her right up until the time of her death. Taking into account all of the circumstances, I am satisfied the deceased's care and supervision was appropriate and of a very high standard.

MEDICAL HISTORY

11. As noted above, when the deceased was born at the start of September 2005 she appeared to be a normally developed and healthy baby girl. She was discharged from hospital to live with her parents and her extended family.

12. When the deceased returned to hospital on 15 October 2005 her health had undergone a fundamental and irreversible change. Following investigations at PMH she was found to have sustained extensive injuries, including
    - severe brain injury;
    - retinal haemorrhages;
    - duodenal trauma;
    - partially healed fracture of the right distal radius (right forearm) that was dated as at least 10 to 14 days old and did not correlate with the brain injuries;
    - greenstick fracture of the right ulna (right forearm);
    - corner fracture of the right humerus (right upper arm)'
    - corner fracture of the distal right femur (right thigh bone near knee joint);

[5] Section 22(1)(a) *Coroners Act*.
[6] Exhibit 3.
[7] Exhibits 1 and 2.

- bucket handle fracture of the right tibia and fibula (right shin bones near knee joint); and
- corner fracture of the left tibia and possibly fibula (left shin bone near knee joint).

13. The injuries were assessed as non-accidental by PMH staff.[8] No person admitted to having deliberately caused the injuries, although the deceased's mother made some admissions that she may have caused some of the injuries accidentally through rough handling. Subsequent investigations by police and the Department did not lead to any person being charged.

14. The deceased was diagnosed with spastic quadriparetic cerebral palsy, profound developmental delay, severe visual impairment, epilepsy, sleep apnoea and asthma. The deceased was fed by a tube into her stomach and was wheelchair dependent. She had minimal functional ability and was dependent for all her care needs. She had limited ability to vocalise and mainly made her needs known by smiling and body language.[9]

15. The deceased's medical conditions, in particular her severe cerebral palsy, were considered to be 'life limiting disabilities' and she was not expected to live to adulthood.[10] It was anticipated that she might develop additional medical complications over time that would require additional forms of care and treatment. Her care had to incorporate careful monitoring for secondary medical complications such as chest infections, pressure areas and pathological fractures.[11]

THE DECEASED'S FOSTER PLACEMENT

16. The deceased's foster carers have been caring for disabled children for many years through a private agency, Uniting Care West. All of the children they have looked after have had special needs and required fulltime care.[12]

17. They became foster carers for the deceased on 1 June 2006, while they were also caring for at least one other special needs child. The deceased was only 9 months old at that time. The deceased's foster carers were initially told that they would only be caring for the deceased for an intermediate period before she was possibly reunited with her biological parents. They were also told that the deceased's life expectancy had been drastically reduced due to her medical conditions, and she was not expected to live for more than a couple of years.[13]

18. As a result of her acquired brain injury and epilepsy, the deceased required full-time care and could not be left alone. Her breathing required constant monitoring and she received daily medication. The deceased's foster carers described the deceased suffering from regular fits, in the region of 20 to 40

[8] Exhibit 1, Tab 24B.
[9] Exhibit 3, Tab 24.
[10] Exhibit 3, Tab 15.1.
[11] Exhibit 3, Tab 24.4.
[12] Exhibit 3, Tab 10 and Tab 11.1.
[13] Exhibit 3, Tab 10 and Tab 11.1 and Tab 24.4.

fits per day. They gave the deceased preventative seizure medication and also two different types of medication after a fit, depending on the number and length.[14]

19. Throughout the time they cared for her, the deceased needed everything done for her, including her bathing, feeding and general care. She was only able to communicate on a limited level but she was able to tell her foster carers through laughing, smiling or crying and body language enough for them to understand her needs, including when she was hungry, thirsty or wanting attention.[15]

20. As noted above, the deceased had difficulty breathing and her breathing required regular monitoring. If the deceased's breathing became laboured during the day she was given generic Ventolin. It was also common for the deceased to stop breathing for short periods throughout the night. The deceased's foster mother slept in a bed in the same room as the deceased so that she could monitor her closely. If the deceased's foster mother noticed that the deceased had stopped breathing, she would touch the deceased's shoulders and say her name. This would usually prompt the deceased to take a gasp of air in and then she would return to breathing normally.[16]

21. The deceased also required regular visits to Princess Margaret Hospital in Perth on a weekly or fortnightly basis for check-ups and regular monitoring of her condition.[17] For example, the deceased's foster carers were required to transport the deceased to Perth for medical appointments on 57 occasions between 2010 and 2011.[18]

22. The deceased's foster mother is a registered nurse and both foster carers were volunteer ambulance officers. They understood what would be required to provide appropriate care for the deceased, and were able to provide that care.[19]

23. Over the years the deceased's life expectancy was extended from two years, to four years and up to eight years, but her foster carers noted that over that time her need for care became greater.[20] In 2011 the deceased's usual paediatrician, Dr Anna Gubbay, noted that the deceased's significant severe comorbidities constantly placed her life at risk. Dr Gubbay wrote to the Department in January 2011 to express her view that it was important to establish a clear, documented resuscitation plan to detail the course of action that was to occur in the event of cardio respiratory arrest for the benefit of PMH staff. Her foster carers had expressed the view that they did not feel invasive intervention was appropriate and Dr Gubbay supported a plan for non invasive measures to be given in such circumstances in order to keep the deceased comfortable.[21]

[14] Exhibit 3, Tab 10 and Tab 11.1.
[15] Exhibit 3, Tab 10 and Tab 24.7.
[16] Exhibit 3, Tab 11.1.
[17] Exhibit 3, Tab 10 and Tab 11.1.
[18] Exhibit 3, Tab 24A.
[19] Exhibit 3, Tab 11.1.
[20] Exhibit 3, Tab 10.
[21] Exhibit 3, Tab 24B and Tab 24.6.

24. Discussions had then been undertaken by Departmental staff with biological family members and the deceased's foster carers to develop a resuscitation plan. The general consensus seems to have been that the deceased should be kept comfortable and allowed to pass away naturally in the event that her condition deteriorated, but the deceased's biological family also expressed a preference that the deceased be kept alive until her family had had an opportunity to come and say goodbye. The difficulty with reconciling the preference for non-invasive treatment, but providing this opportunity for the family meant that a definitive decision, on a resuscitation plan for the deceased had not been finalised at the time of her death.[22]

25. The deceased's last formal care plan was approved on 31 October 2012 following a meeting with the deceased's foster carers and relevant Departmental staff on 21 September 2012. It was agreed the deceased would stay in her placement with her foster carers with ongoing support from the Department. It was noted at the time that the deceased's biological parents had a day of unsupervised contact with the deceased on a monthly basis and increasing contact with her extended family, which had been very successful and was progressing towards overnight stays.[23]

26. It was noted during the meeting that the deceased's seizures were becoming worse and she was experiencing a grand mal on a weekly basis. Dr Gubbay repeated a request for the Department to complete discussions in relation to providing the medical staff at PMH with some clear guidelines to place on their file in the event that the deceased become unwell with a life threatening illness in the future.[24]

EVENTS IN THE WEEK PRIOR TO DEATH

27. The deceased attended the Special Education Program at Avon Vale Primary School in Northam on a regular basis during the week. She was involved in therapy programs including a sensory programme and daily movement programme and was generally happy and settled at school.[25] However, on Tuesday, 19 March 2013 the deceased's foster mother received a phone call from the deceased's teacher. The teacher believed the deceased may have caught a virus as the deceased had been crying as if she was in pain and was not acting like her normal self. The teacher suggested the deceased should be taken home.[26]

28. The deceased's mother immediately went to the school, collected the deceased and took her straight home. The deceased's foster mother observed that the deceased appeared to be feeling unwell, was crying a lot more than usual and appeared to be having difficulty breathing. She was later prescribed some antibiotics by the GP on the 20 March 2013 and the

[22] T 9; Exhibit 3, Tab 24B.
[23] Exhibit 3, Tab 24.7.
[24] Exhibit 3, Tab 24. 7.
[25] Exhibit 3, Tab 24.8.
[26] Exhibit 3, Tab 11.1.

deceased's foster mother decided to keep the deceased home from school for the rest of the week to monitor her condition.[27]

29. While the deceased did not recover fully, she initially did not appear to require professional medical attention. However, on the Sunday afternoon the deceased's foster carers became concerned that the deceased's condition had begun to deteriorate further. They noticed the deceased had begun to labour more with her breathing, was lethargic and her body temperature had dropped. The deceased's foster carers decided to take the deceased to Princess Margaret Hospital, and the deceased was subsequently admitted that evening with an apparent chest infection. She was appropriately treated with antibiotics. The deceased was prone to increased seizure frequency when unwell, so this was managed by the addition of another drug to her usual seizure treatment.[28]

30. It was initially planned that the deceased would be discharged home on Tuesday, 26 March 2013. However, that day the deceased's body temperature dropped again and her doctors decided to keep her in for another night.[29]

31. The deceased's condition improved throughout the following day and she was eventually discharged home during the afternoon of Wednesday, 27 March 2013 with a plan to continue oral antibiotics at home. When the deceased returned home that night she appeared to be fully recovered and when she went to bed nothing appeared out of the ordinary. During the night her breathing continued to appear normal.[30]

32. On Thursday, 28 March 2013 the deceased remained her usual self and appeared fully recovered from her recent illness. At the time the deceased's foster mother put the deceased to bed that night all appeared correct and normal. When the deceased's foster mother woke up at about 11.30 pm that night the deceased was making normal sleeping noises.[31]

EVENTS ON 29 MARCH 2013

33. Sadly, things changed overnight. At approximately 1.30 on Friday, 29 March 2013 the deceased's foster mother woke up and observed that the deceased's breathing was laboured and she was pausing between breaths. She immediately checked the deceased's blood oxygen levels and temperature and noted that both were low.[32]

34. The deceased's foster mother woke her husband and told him that the deceased required medical attention. They knew that time was vital given her medical history. As both the deceased's foster carers were volunteer ambulance officers they were aware that it would take a minimum of 40

[27] Exhibit 3, Tab 10 and Tab 11.1.
[28] Exhibit 3, Tab 10 and Tab 11.1 and Tab 15.
[29] Exhibit 3, Tab 11.1.
[30] Exhibit 3, Tab 11.1.
[31] Exhibit 3, Tab 11.1.
[32] Exhibit 3, Tab 11.1.

minutes for an ambulance to reach their house. Accordingly, they made the decision that it would be quicker for them to transport the deceased to hospital themselves. After making that decision they transferred the deceased into one of their vehicles and drove immediately to Northam Regional Hospital, which was usually about 30 minutes' drive from their home. The deceased's foster father drove the van while her foster mother sat with her in the back seat of the van with the deceased upright in her lap. The deceased's foster mother noticed that the deceased was crying and struggling to breathe during the journey.[33]

35. A few minutes before they reached the hospital the deceased gave a cry and stopped breathing altogether. Her foster mother immediately delivered a few blows to the deceased's back in an attempt to start her breathing again but was not successful. She could not attempt CPR as the van was too unstable. They arrived very shortly afterwards at Northam Regional Hospital. The deceased's foster mother estimated it had taken them approximately 20 minutes to drive from their home to the hospital. On arrival the deceased's foster mother got the deceased out of the car while her husband ran to the emergency department door and rang the bell.[34]

36. A nurse answered the door and quickly led the deceased and her foster carers into the emergency department and alerted the other staff that there was a Code Blue. Other nursing staff immediately attended and began to give the deceased CPR in an attempt to resuscitate her. The doctor on duty arrived very shortly afterwards and was later joined by another doctor to assist in resuscitation efforts. After a lengthy period of resuscitation a doctor announced that she had passed and certified her life extinct at 3.25 pm on 29 March 2013.[35]

37. The deceased's foster carers were allowed some time with her and the police were notified of the death by hospital staff given the deceased was a child in care.

CAUSE AND MANNER OF DEATH

38. An initial external post mortem examination was conducted on 3 April 2013 and then a full post mortem examination was performed on 9 April 2013. Dr White, a forensic pathologist, undertook the full internal examination after being provided with some information about the deceased's extensive medical history and the circumstances leading to her death. Dr White noted heavy congested lungs with thick mucus plugging the airways, congestion of the liver and early decompositional changes. Histology showed congestive changes in the lung, but no evident pneumonia, and features in the pancreas consistent with acute pancreatitis.[36]

39. Microbiological studies showed detection of Rhinovirus A within lung tissue consistent with the likely presence of the common cold, and widespread

[33] Exhibit 3, Tab 11.1 and Tab 11.2.
[34] Exhibit 3, Tab 11.1 and Tab 11.2.
[35] Exhibit 3, Tab 4 and Tab 11.1 and Tab 12.
[36] Exhibit 3, Tab 6.

growth of Staphylococcus aureus MRSA-type, although there was no evident sepsis or inflammation so its significance is uncertain.[37]

40. The brain was noted to be small during the internal post mortem examination. Formal neuropathology was completed by neuropathologist Dr Fabian. Dr Fabian found widespread global atrophy of the cerebral hemispheres and cerebellum with bilateral loss and cavitation of the frontal, temporal and occipital lobes with relative sparing of the inferior temporal lobes, basal ganglia, brain stem and cerebellum.[38]

41. Toxicology was undertaken and showed amounts of prescription-type medication.[39]

42. At the completion of all investigations Dr White formed the opinion that the cause of death was consistent with respiratory failure and acute pancreatitis in a young girl with cerebral palsy, seizure disorder and chronic respiratory problems.[40]

43. I accept and adopt the conclusion of Dr White as to the cause of death.

44. I find that the manner of death was natural causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

45. 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.

46. To assist me in that task, Dr Sathiaseelan Nair, a Senior Consultant Paediatrician and Head of Department at St John of God Midland Public and Private Hospitals, reviewed the deceased's history and prepared an opinion addressing the standard of care, treatment and supervision the deceased received from her carers.[41] Dr Nair also gave oral evidence at the inquest.

47. Dr Nair expressed the opinion that the Department ensured the safety needs and the psychosocial needs of the deceased were met at all times in her life. Given the complexity of the deceased's extensive medical needs and the high intensity of her daily needs, Dr Nair observed that it was appropriate for the deceased to be placed with her specialist foster carers, who had significant experience, skill and capacity to meet all the deceased's needs, rather than her biological family. Dr Nair made the observation that it came through in reading the notes that this was a loving set of foster carers. Nevertheless, Dr Nair also acknowledged that the Department made significant attempts to ensure that the deceased had regular contact with her biological family and extended family, which was culturally appropriate.[42]

[37] Exhibit 3, Tab 6.
[38] Exhibit 3, Tab 6 and Tab 8.
[39] Exhibit 3, Tab 6 and Tab 9.
[40] Exhibit 3, Tab 6.
[41] Exhibit 3, Tab 15.
[42] T 11.

48. Dr Nair considered that there was good communication between all the relevant agencies and the foster carers and biological parents and had no concerns in regards to the extent or quality of the care provided.[43]

49. In relation to the events at the time of her death, Dr Nair acknowledged that the deceased's foster mother did the best she could to stimulate the deceased's breathing on the way to hospital and noted that the deceased only stopped breathing a few minutes away from the hospital. Dr Nair formed the opinion the resuscitation attempts at the hospital were of a satisfactory standard. Dr Nair did make some observations about staffing levels as there was no one to scribe during the resuscitation, but also felt that Dr McKenna made very good notes shortly after the resuscitation.[44]

50. In keeping with the deceased's biological family's request to be able to say goodbye, Dr Nair observed that the resuscitation efforts went beyond the usual length in order to try and keep her alive and he described it as a "very prolonged resuscitation."[45] Sadly, those efforts were unsuccessful but given her complex medical background, Dr Nair expressed the opinion that resuscitation would have been very difficult and no more could have been done.[46]

51. Mr Andrew Geddes, the Executive Director of Country Services and Therapeutic Care for the Department of Communities, Children Protection and Family Support Division, also gave evidence at the inquest. Mr Geddes had reviewed the Department's material in relation to the deceased and described her placement with her fosters carers as "an extremely successful placement."[47] It was apparent that the level of cooperation between the carers and the Department was good, and there was a good relationship between the carers and the biological family.[48] Mr Geddes expressed the opinion that the foster carers gave the deceased "the best quality of life that we could have hoped for."[49]

CONCLUSION

52. The deceased was a young Aboriginal girl who tragically had sustained life limiting disabilities as a baby when she was seriously injured by an unidentified person. As a result of the harm she had experienced while in the care of her family, the deceased was taken into the care of the Department and she remained in the care of the Department until her death.

53. Due to her complex medical needs, the Department had placed the deceased in the care of specialised foster carers who not only had the necessary skills to meet her medical needs but were also able to provide her with a loving

[43] T 12.
[44] T 13.
[45] T 13.
[46] T 13 - 14.
[47] T 7.
[48] T 8.
[49] T 8.

and emotionally supportive environment throughout her short life. The Department facilitated contact with the deceased's biological family where possible and in her final years she had enjoyed happy visits with her extended family.

54. The deceased was well supported in the community through her school, the Department and the Disability Services Commission and she received high level medical care through a coordinated effort of her local general practitioners and specialist care from PMH and other medical and therapeutic services.

55. The deceased's early death had been anticipated and it had been agreed by all involved in her care that her life should not be prolonged unnecessarily through medical intervention, although there was a preference for her to be kept alive at least long enough to let her biological family come to say goodbye. In keeping with that request, significant efforts were made to resuscitate the deceased when she went into respiratory arrest, but she could not be revived.

56. I am satisfied that the deceased was provided with a very high level of supervision, treatment and care from the time she was taken into the care of the Department until her death.

57. The community is very fortunate to have people such as the deceased's foster carers, who are prepared to take on the great responsibility of caring for a child with significant health needs. Not only did they tend to the deceased's physical needs, but they also opened their hearts to her and cared for her like she was their own child. The love and care they provided, with the support of the Department, her doctors and other agencies, enabled the deceased to have a high quality of life despite her significant physical and mental impairment. Everything was done to prolong her life, but sadly her death was an inevitable consequence of the terrible harm she suffered as a very young baby before she came into the care of the Department, which had permanently compromised her health.

S H Linton
Coroner
January 2018