Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

AMENDED RECORD OF INVESTIGATION INTO DEATH

Ref: 16/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of a male child referred to as ***Child L*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***30 April 2019*** *–* ***1 May 2019*** *find that death occurred on* ***27 March 2015*** *at* ***Northam*** *and was consistent with* ***epileptic seizure with aspiration*** *in the following circumstances:-*

Counsel Appearing:

Mr D Jones assisted the Coroner

Ms R Panetta (State Solicitor's Office) appeared on behalf of the Department of Communities; the East Metropolitan Health Service; the Child and Adolescent Health Service; and the Western Australian Country Health Service.

Table of Contents

NOTE REGARDING SUPRESSION ORDERS

i. In a letter received by the Court on 11 October 2018, the deceased's father expressed his strong view that the failure to mention the deceased's name at the inquest and in my Finding was both disrespectful to the deceased, and insulting to his (the deceased's father's) cultural heritage.

ii. At the start of the inquest, the deceased's full name was mentioned in open court and his first name was used throughout the inquest. However, I made it clear that the deceased's name was not to be published outside of the court because of a Suppression Order made by the Deputy State Coroner on 8 September 2018 under section 49 of the *Coroners Act 1996 (WA).*[1]

iii. That order was necessary because the deceased's sister is in the care of the Chief Executive Officer of the Department of Communities and pursuant to section 237(2) of the *Children and Community Services Act 2004 (WA)*, her identity must be protected. Therefore, as a necessary consequence, the deceased's name had to be suppressed.

iv. On 1 May 2019, I made a Suppression Order, [under section 49 of the *Coroners Act 1996 (WA)*], with respect to the deceased's sister's name which was also mentioned in open court.[2] My reason for doing so was to make certain that her name was protected.

v. The terms of the respective Suppression Orders are as follows:

SUPPRESSION ORDERS

Suppression of the deceased's name from publication and is to be referred to as Child "L".

(Deputy State Coroner, 06.09.18)

Suppression of the deceased's sister's name or any evidence leading to identification is not to be made.

(Coroner Jenkin, 01.05.19)

[1] ts 30.04.19, p2
[2] ts 30.04.19, p96

INTRODUCTION

1. Child L (the deceased) was declared dead at Northam Hospital at 8.10 am on 27 March 2015. He was 13-years of age and his death was consistent with an epileptic seizure with aspiration.

2. I held an inquest into the deceased's death on 30 April 2019 and 1 May 2019. The deceased's mother attended the second day of the inquest.

3. The documentary evidence at the inquest included a report (with attachments) prepared by the WA Police[3], expert reports, the deceased's medical records and a number of letters and emails from the deceased's father.

4. Together, the Brief comprised three volumes.

5. The following witnesses gave oral evidence at the inquest:

i. Dr J. Silberstein, (paediatric neurologist);

ii. Professor D. Joyce, (physician & clinical toxicologist);

iii. Dr S. Nair, (senior consultant paediatrician);

iv. Mr N. Trahanas, (Director, Perth District Office, Department of Communities); and

v. Dr T. Ghia, (paediatric neurologist).

6. At the conclusion of the oral evidence, I was assisted by a heartfelt statement made to the Court by the deceased's mother. It was a courageous thing for her to do. She said that she and the deceased's father had done their best to care for the deceased within the limits of their respective abilities.

7. The inquest focused on the management of the deceased's epilepsy and the circumstances surrounding his death.

[3] Exhibit 1, Vol. 1, Tab 6, Report - Coronial Investigation Squad

THE DECEASED

Background

8. The deceased was born on 13 March 2002 and at all relevant times, lived with his father and younger brother in Northam. He had a younger sister, but she had not lived with the deceased since her birth. The deceased attended school in Northam and received support from education assistants, health professionals and at various times from the Disability Services Commission[4] (DSC) as it then was.[5,6]

9. The Department of Communities (the Department), as it now is, had numerous interactions with the deceased's family. These interactions were mostly in the context of child safety assessments related to reports of domestic violence between, and illicit drug use by, the deceased's parents.[7]

10. I carefully read a number of letters and emails sent to the Court by the deceased's father. Although much of that correspondence dealt with matters outside the scope of this inquest, what was abundantly clear to me, was that the deceased was greatly loved and that the deceased's father did his best to care for the deceased and his brother in difficult circumstances.[8,9]

Medical conditions[10]

11. The deceased was diagnosed with autism spectrum disorder when he was about 3 years of age. He also had behavioural issues and a cognitive impairment.[11] He was diagnosed with generalised epilepsy syndrome in 2013.

12. The deceased exhibited a number of challenging behaviours related to his medical conditions and as a consequence, I accept that his day to day management would have been difficult and stressful. In addition to the deceased, his father also had the care of the deceased's younger brother, who was diagnosed with autism spectrum disorder.[12]

---

[4] The Disability Services Commission is now part of the Department of Communities
[5] Exhibit 1, Vol. 1, Tab 6, Police Investigation Report, p7
[6] Exhibit 1, Vol. 2, Tab 4, Service Provision Review, Disability Services Commission (28.12.16)
[7] See the section in this Finding headed "Child Safety Issues"
[8] Exhibit 1, Vol. 1, Tab 2, Letters and emails from the deceased's father
[9] See also: ts 01.05.19 (Schilling), pp160-161
[10] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein & ts 01.05.19 (Nair), pp76-77
[11] Exhibit 1, Vol. 1, Tab 6.17, Letter - Prof. Nagarajan (Head, PMH Department of Neurology) (27.05.15)
[12] Exhibit 1, Vol. 1, Tab 6, Police Investigation Report, p7

EPILEPSY & SUDEP

13. Before examining the deceased's clinical management, it is appropriate that I make some brief comments about the nature of epilepsy and a rare, though well recognised complication of epilepsy, namely Sudden Unexpected Death in Epilepsy (SUDEP).

Epilepsy

14. In broad terms, epilepsy is a neurological disorder of the brain characterised by a tendency to have recurrent seizures. A seizure occurs when there is a disruption of the normal electrochemical activity of the brain.[13] There are several different types of seizures. At the inquest, reference was made to tonic clonic seizures and absence seizures. Both absence and tonic clonic seizures are forms of generalised onset seizures, meaning both sides of the brain are affected from the outset.[14]

15. Tonic clonic seizures are characterised by stiffening of the body (tonic phase) followed by shaking or rhythmic jerking (clonic phase).[15]

16. Absence seizures involve a momentary lapse in awareness and responsiveness and may appear as brief staring episodes or daydreaming. These types of seizures usually last less than 30 seconds. Absence seizures tend to occur more frequently that tonic clonic seizures and the two are often associated.[16]

17. There are a number of known causes of epilepsy including structural issues such as head injury, stroke, brain infections and brain tumours. Epilepsy may also occur as a result of genetic factors, where brain proteins are adversely affected. The deceased's epilepsy was thought to have a genetic cause.[17]

18. There is a known link between epilepsy and autism with about 30% of children with autism also being diagnosed with epilepsy.[18]

---

[13] https://www.healthdirect.gov.au/epilepsy
[14] https://www.healthdirect.gov.au/epilepsy
[15] ts 30.04.19 (Silberstein), p8
[16] ts 30.04.19 (Silberstein), p8
[17] ts 30.04.19 (Silberstein), p44
[18] ts 30.04.19 (Silberstein), p44

Sudden Unexpected Death in Epilepsy (SUDEP)

19. The evidence in this case suggests that the deceased's death is best understood in the context of SUDEP. This is an uncommon but well recognised phenomenon associated with epilepsy. With SUDEP, death may occur as a result of respiratory obstruction, respiratory arrest or cardiac arrhythmia.[19,20]

20. In terms of the mechanism of death by SUDEP, Dr Silberstein noted:

> "*Most seizures will stop spontaneously by themselves and don't lead to any harm, but they can in rare cases lead to harm, including brain damage or death. There are various mechanisms for that. The seizure can result in vomiting and aspiration of the vomit, and cause obstruction of the airway for that reason. Also, the seizure itself can cause…cessation of breathing. Seizures can also sometimes cause rhythm disturbances in the heart, so they can cause the heart to stop or go into an abnormal rhythm, and…it's thought that in some cases that's the mechanism*".[21]

21. In terms of the incidence of SUDEP, Dr Silberstein said:

> "*…the annual incidence in one study was between 0.09 and 0.35 per thousand people with epilepsy. In people with refractory epilepsy, so epilepsy where it hasn't been controllable with medication, the rate is higher…say, between one and six per thousand.*"[22]

22. Dr Nair said that in addition to intractable or refractory epilepsy, sleep deprivation and increased weight (which causes airway issues) both increase the risk of SUDEP occurring.[23] All of these risk factors applied to the deceased.

23. Dr Silberstein said that because of the risks associated with epilepsy, every effort is made to treat the condition as effectively as possible".[24]

---

[19] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 57 and ts 30.04.19 (Silberstein), p8
[20] ts 01.05.19 (Ghia), p151
[21] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 51 and ts 30.04.19 (Silberstein), p31
[22] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 51 and ts 30.04.19 (Silberstein), pp44-45
[23] ts 01.05.19 (Nair), p85 and see also: Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 53
[24] ts 30.04.19 (Silberstein), p31

MANAGEMENT OF THE DECEASED'S EPILEPSY[25]

24. The deceased had his first recorded tonic clonic seizure, reportedly lasting 30 minutes, on 17 December 2012. The deceased was brought to the Northam Hospital by ambulance after his father had revived him by performing CPR. A family history of epilepsy was noted but an electrocardiogram (ECG) was normal.[26]

25. The deceased was seen in the emergency department of Princess Margaret Hospital (PMH) on 27 December 2012. He was referred for an ECG on 22 February 2013 but did not attend. This was the first of a number of specialist and other appointments that the deceased did not attend.[27]

26. The deceased was admitted to PMH on 31 March 2013 following his second known tonic clonic seizure. This seizure reportedly lasted 10 minutes. An ECG was ordered but not completed during the deceased's admission. A blood test was attempted but because of the distress this caused the deceased, it was not carried out.[28]

27. An ECG performed after the deceased had been discharged (3 April 2013) was abnormal and recorded an absence seizure. On the basis of this ECG and his two known tonic clonic seizures, the deceased was diagnosed with generalised epilepsy syndrome.[29]

28. The deceased was prescribed 500 mg of the anti-epileptic medication, levetiracetam (the trade name of which is Keppra) twice daily. There was some initial confusion about the correct daily dose but this was corrected. After a phone review on 17 June 2013, the deceased's Keppra dose was increased to 750 mg twice daily because he was still having seizures.[30]

29. A phone review in July 2013 was unsuccessful (no answer), but the deceased was reviewed on 13 August 2013 in the general paediatric clinic at PMH.[31]

---

[25] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, paras 1-49
[26] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 1
[27] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 1
[28] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 1
[29] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 12
[30] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 3
[31] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 3

30. At that stage, the deceased seemed to be doing well and no changes were made to his medication regime. A neurology appointment was booked for September 2013.[32]

31. The deceased missed a neurology clinic appointment on 4 September 2013 but he was seen by Dr Ghia (at the time, a epilepsy fellow) on 4 December 2013.[33] At that time, the deceased's father reported that the deceased was having at least three to four "*big seizures*" per month, at least half of which were said to have occurred as the result of missed doses of Keppra.[34]

32. Dr Ghia recalled the deceased's father saying he had been having trouble getting the deceased to take his Keppra and had used a liquid form of the medication, which he concealed in the deceased's food.[35,36]

33. Although the pharmaceutical records in the brief show that from 5 September 2014 onwards, Keppra was prescribed to the deceased in tablet form, Dr Ghia was aware of Keppra syrup having been dispensed to the deceased by the PMH pharmacy.[37]

34. Dr Ghia said that because this was the first time the deceased was seen at the PMH clinic, it was important to try to build a therapeutic relationship and avoid the impression that the deceased's father was being chastised for the deceased's missed doses. However, the importance of dose compliance with Keppra was discussed.[38]

35. After discussions with a more senior colleague, Dr Ghia increased the deceased's dose of Keppra to 1,000 mg twice per day with a plan to add lamotrigine if the deceased's seizures continued. Because the deceased's father did not wait to see the consultant after seeing Dr Ghia, the information about the increased dose of Keppra was communicated to him by phone.[39]

---

[32] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 3
[33] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 4
[34] ts 01.05.19 (Ghia), p142 & p158
[35] ts 01.05.19 (Ghia), p142 & p158
[36] Although non-compliance with medication was of concern to Dr Nair, the deceased's father never raised any difficulty getting the deceased to take medication with Dr Nair, see ts 01.05.10 (Nair), p 89
[37] Exhibit 1, Vol. 2, Tab 6, Records - Discount Drug Store (Northam) and ts 01.05.19 (Ghia), p158
[38] ts 01.05.19 (Ghia), pp142-143
[39] ts 01.05.19 (Ghia), p137 and Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 4

36. In an entry in the deceased's medical notes dated 23 January 2014, Dr Ghia noted that the deceased's seizure control had been poor over the Christmas period with one tonic clonic seizure per week and two to three absence seizures per day being noted. The deceased's Keppra was increased to 1,250 mg twice daily, with a plan to increase this to 1,500 mg twice daily if seizures persisted.[40]

37. On 15 April 2014, the deceased underwent a cranial MRI and a blood test under a general anaesthetic. The MRI was normal, but the blood test showed mildly abnormal liver function, which was thought to be due to fatty infiltration of the liver as a result of the deceased's high body mass index (BMI).[41,42]

38. On 14 May 2014, the deceased was seen in the neurology clinic at PMH. Although the frequency of his seizures was reported to have reduced, because they were persisting the plan was to introduce lamotrigine and progressively increase the dose to 200 mg twice daily.[43]

39. Ampoules of liquid midazolam were also prescribed for the management of seizures lasting more than 5 minutes. This medication is administered by squeezing an ampoule of the medication onto the inside of the patient's cheek.[44]

40. Dr Ghia said that carers are told to take the child to an emergency department as soon as the midazolam has been given. Carers are also advised to ensure midazolam ampoules are available at locations such the child's school, the homes of family members and so on.[45]

41. The deceased did not attend a neurology clinic appointment at PMH in August 2014 or a paediatric clinic appointment in October 2014. The deceased's father cancelled a neurology clinic appointment in October 2014.[46]

---

[40] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 5
[41] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 19
[42] Exhibit 1, Vol. 1, Tab 6.16, Princess Margaret Hospital MRI report (15.04.14)
[43] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 6
[44] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 6
[45] ts 01.05.19 (Ghia), pp144-146
[46] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 7

42. As Dr Ghia noted, these missed appointments were of concern. Had the deceased attended the appointments in August and October 2014, his seizure activity would have been reviewed and any necessary adjustments to his medication regime could then have been made. Dr Ghia agreed that where patients missed appointments, their treatment would not be optimal.[47]

43. On 18 September 2014, the deceased was brought to the Northam Hospital by ambulance after he had a seizure at school. This appears to be the deceased's only recorded attendance at an emergency department in 2014.[48]

44. In October 2014, Dr Ghia noted advice from the deceased's epilepsy nurse that lamotrigine had been discontinued by the deceased's GP. This was apparently because it had caused a rash and upset the deceased's stomach, although this is not entirely clear. By this time, the deceased's weight was 87 kg.[49]

45. As Dr Ghia observed, lamotrigine is a very effective medication and would have been a useful adjunct to the deceased's dose of Keppra. However, a rash is a known side effect of lamotrigine and can be life-threatening.[50]

46. Both Dr Silberstein and Dr Ghia would have supported a trial reintroduction of lamotrigine, although Dr Ghia felt this would have required inpatient admission and blood tests. As noted, the deceased was known to have difficulties tolerating blood tests.[51]

47. In any event, after discussions with a senior colleague, Dr Ghia increased the deceased's dose of Keppra to 1,500 mg in the morning and 1,750 mg at night. A further ECG was planned and an outpatient clinic appointment was booked.[52]

48. On 16 October 2014, Ms Melvin (community and child health nurse) referred the deceased to the Northam clinic conducted by Dr Nair.[53]

---

[47] ts 01.05.19 (Ghia), pp147-148
[48] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 22
[49] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 60
[50] ts 01.05.19 (Ghia), p157 and see also: ts 30.04.19 (Silberstein), p13
[51] ts 01.05.19 (Ghia), pp157-158 and ts 30.04.19 (Silberstein), p13
[52] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 7
[53] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, p4 and ts 01.05.19 (Nair), p63

49. The referral noted that the deceased had recently been seen by his GP but had missed appointments at PMH. Ms Melvin noted that the deceased was due to be reviewed in November 2014 and asked if Dr Nair would conduct this review.[54]

50. Dr Nair told Ms Melvin he would see the deceased at his Northam clinic on 6 November 2014 and contacted both the deceased's father and the deceased's school to make the necessary arrangements.[55]

51. I note that Dr Nair's Northam clinic was a service he started on his own initiative and was in addition to his role of Head of Paediatrics at Swan District Hospital (SDH), as it then was. Dr Nair's clinic received no funding and had no administrative, secretarial or IT support. All referrals were emailed or posted to Dr Nair direct. [56]

52. Dr Nair visited Northam to conduct the clinic every four to eight weeks for one or two days depending on his availability. His clinic would see patients from 8.30 am to after 5.00 pm without a break. It is most unfortunate that this service ceased operating in 2015 when SDH closed and St John of God Hospital, Midland opened.[57]

53. On 4 November 2014, Ms Melvin sent Dr Nair an email to advise that a social worker from PMH had contacted the deceased's school to express concerns for the family. The PMH social worker asked to be advised if the family did not attend their appointment with Dr Nair. Ms Melvin also confirmed that the deceased was receiving Schools Plus funding for his autism and epilepsy.[58]

54. With respect to the deceased's father, Ms Melvin noted:

> "*[The deceased's father] has been challenging to work with in the past and can be somewhat manipulating at times by making many different excuses for not attending school or important appointments.*"[59]

---

[54] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, p4 and ts 01.05.19 (Nair), p63
[55] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, p4 and ts 01.05.19 (Nair), p63
[56] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, p2 and ts 01.05.19 (Nair), p61
[57] ts 01.05.19 (Nair), p61, p83 and p89
[58] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, p4
[59] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair: Annexure C - Email from Ms Melvin (04.11.14)

55. The deceased and his father attended the clinic appointment with Dr Nair on 6 November 2014.[60] Dr Nair's assessment was that the deceased's epilepsy was poorly controlled and because of the deceased's obesity, Dr Nair considered the possibility that the deceased had Prader Willi Syndrome[61] or Angelman Syndrome.[62]

56. Dr Nair considered that the deceased's case was complex. The complexity arose from the combination of the deceased's autism, intractable epilepsy, cognitive impairment and obesity. In addition, there were behavioural issues and significant social issues impacting on the deceased. Dr Nair said that the deceased's case was in the top 10% of the most severe cases he had seen in over 25 years of practice.[63]

57. The deceased did not attend a dietician outpatient appointment on 6 November 2014 which had been arranged with his father on 4 November 2014, nor did he attend an appointment with the dietician on 20 November 2014.[64]

58. On 4 December 2014, Dr Nair reviewed the deceased in his Northam clinic. He noted that despite the deceased's high dose of Keppra, he was still having seizures with one tonic clonic seizure per week (lasting less than 5 minutes) and one to two absence seizures every couple of days.[65]

59. Dr Nair provided a letter to the deceased's school with the intention of securing increased funding. Dr Nair also provided the deceased's father with a Seizure Management and Emergency Action Plan and wrote out a prescription for midazolam ampoules. Dr Nair reinforced the need to take the deceased to an emergency department immediately thereafter.[66]

60. At this review, Dr Nair was made aware of significant safety concerns relating to the deceased that Ms Melvin had reported to the Department.[67,68]

---

[60] ts 01.05.19 (Nair), pp65-66
[61] A genetic disorder that causes obesity, intellectual disability and shortness in height
[62] A genetic disorder causing developmental disabilities and nerve-related symptoms
[63] ts 01.05.19 (Nair), p62 and p92
[64] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes - Dietetic outpatient notes (4, 6 & 20,11.14)
[65] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, pp6-7 and ts 01.05.19 (Nair), p69-70
[66] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, p7 and ts 01.05.19 (Nair), p68
[67] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, pp7-8 and ts 01.05.19 (Nair), pp70-71
[68] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair: Annexure F – Outpatient notes (04.12.14)

61. Ms Melvin's concerns included:

i. the deceased and his brother recently witnessing violent behaviour between their parents;

ii. the frequency of the deceased's seizures needing medication review;

iii. the deceased's non-attendance at important PMH neurology clinic appointments and booked electroencephalogram (EEG);

iv. the deceased not attending the GP after seizures at school and home on numerous occasions;

v. a report from the deceased's father that the deceased's mother was allegedly stealing the deceased's medication;

vi. the deceased's poor attendance at school because of his increasing seizures;

vii. the fact that both boys had autism and were unable to care for themselves;

viii. financial concerns with the deceased's father saying he was unable to afford to feed the boys or pay for required dental treatment;

ix. suspected drug use by the deceased's father and drug use by the deceased's mother (disclosed by the deceased's father); and

x. the deceased's father not "*travelling well*" and requiring respite.[69,70]

62. With respect to the issue of non-compliance with medication, Dr Nair agreed that when consideration is being given to implementing a new medication plan (as was the case for the deceased), it is essential to be confident that the patient's current medication is actually being taken as prescribed. Without that assurance, Dr Nair agreed that any attempt to amend the patient's medication regime was doomed to fail.[71]

[69] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair: Annexure F-3 - Child Safety Nomination (26.11.14)
[70] ts 01.05.19 (Nair), p70
[71] ts 01.05.19 (Nair), p91

63. At the clinic appointment on 4 December 2014, Dr Nair was also given a record which said that from February to December 2014 the deceased had experienced a total of 25 seizures, 13 of which had occurred at school.[72,73]

64. Dr Nair planned to see the deceased again at his clinic in Northam in February 2015. He had a discussion with Dr Ghia about the ongoing seizures and concerns that the deceased was not compliant with medication.[74]

65. On 19 December 2014, Dr Nair's registrar, Dr Bengson, sent an email to the neurology team at PMH outlining Dr Nair's concerns. The email referred to the deceased's increasing seizures despite increased doses of Keppra. Dr Bengson also referred to the fact that the deceased had missed outpatient appointments (including a neurology appointment at PMH on 11 December 2014) and a scheduled EEG (with no rescheduled appointment). The email asked whether a medication change was needed, and when the EEG and follow up by PMH would occur.[75]

66. The deceased was reviewed by Dr Ghia on 13 January 2015. At that time, the deceased's seizure activity was reported to be two absence seizures per week and one tonic clonic seizure every three weeks. Although most of the tonic clonic seizures lasted no more that 1 – 1.5 minutes, buccal Midazolam was reportedly required on three occasions.[76]

67. Medication compliance was reported to be good and it was planned to start the deceased on the anti-epileptic medication topiramate, with a plan to increase the dose to 100 mg twice daily.[77]

68. The deceased's weight gain was noted with concern as by now, his BMI was 35.9, and he was referred to the Changes in Lifestyle Program (CLASP). Dr Ghia also requested social worker involvement.[78]

---

[72] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, pp6-7
[73] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair: Annexure F-5 - Seizure record 2014
[74] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, p7
[75] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair: Annexure G - Email from Dr Bengson (19.12.14)
[76] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 8
[77] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 8
[78] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 8

69. In early February 2015, the deceased's father contacted the deceased's epilepsy nurse to report concerns about the deceased's ongoing seizures. Dr Ghia consulted with colleagues and suggested the deceased's topiramate dose be increased to 150 mg twice daily, his Keppra be reduced and if seizures persisted, the anti-epileptic ethosuximide be introduced.[79]

70. After further contact from the deceased's father, Dr Ghia rang the deceased's GP and gave a telephone recommendation with respect to the prescription of ethosuximide.[80] As Dr Silberstein noted, there is no record of ethosuximide ever having been prescribed.[81]

71. When Dr Nair saw the deceased with his father on 18 February 2015, he was told that the deceased was still having one tonic clonic seizure per week and some absence seizures (lasting 15 seconds). The deceased's father also reported that the deceased had become aggressive at home and at school since starting the topiramate.[82,83]

72. Ms Melvin repeated her concerns about medication compliance and Dr Nair felt that it was imperative to convene a case conference involving the deceased, his father and all relevant agencies (school, child health nurse, Department of Communities Caseworker etc.), in order to:

> "*…get some clarity around the concerns regarding seizure events* [and] *compliance behaviour and map a plan forward to decide on how to proceed with his medication*".[84]

73. As Dr Nair put it, the case conference would provide an opportunity for all of those involved in the deceased's care to be open and frank about their concerns and enable those concerns to be addressed. Dr Nair also felt the conference might identify needs not currently being met.[85]

---

[79] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 9
[80] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 9
[81] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 36
[82] ts 01.05.19 (Nair), p76
[83] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair: Annexure K - Outpatient notes (18.02.15)
[84] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, p11 and see also ts 01.05.19 (Nair), pp75-76
[85] ts 01.05.19 (Nair), p91

74. Dr Nair remained concerned about the deceased's compliance with medication. Notwithstanding the reports about the deceased's aggressive behaviour since starting on topiramate, Dr Nair felt it was important to try to get a clearer understanding of exactly what was going on before making further changes to the deceased's medication regime.[86]

75. The deceased's father told Dr Nair that the deceased was receiving both Keppra and topiramate as prescribed.[87] Dr Nair was keen to persist with topiramate because it has a side effect of supressing appetite and this was considered important in the context of the deceased's increasing weight.[88]

76. It is therefore particularly unfortunate, as I discuss in the section of this Finding dealing with toxicology results, that the deceased was not receiving topiramate in the period before his death.

77. In order to facilitate the case conference, Dr Nair contacted the deceased's case worker at the Department on 26 February 2015 and discussed his concerns. Those concerns were: "*compliance, seizure frequency and management, behaviour and school assistance*".[89]

78. Dr Nair contacted the deceased's father on 27 February 2015 and told him about the planned case conference and discussed the use of the medication risperidone (trade name Risperdal) to address the deceased's aggression.[90,91]

79. There were some difficulties in arranging a date for the case conference relating to school holidays and the availability of the parties, but it was eventually scheduled for 11.30 am on 30 March 2015, three days after the deceased's death.[92,93]

80. Dr Nair was asked whether, with the benefit of hindsight, he thought there was anything that could have improved the outcome for the deceased and his response was: "*…SUDEP is a rare event…You cannot predict these events…*"[94]

---

[86] ts 01.05.19 (Nair), p80
[87] ts 01.05.19 (Nair), p80
[88] ts 01.05.19 (Nair), pp82-83
[89] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, Annexure L - Outpatient notes (26.02.15)
[90] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair, Annexure M - Outpatient notes (27.02.15)
[91] ts 01.05.19 (Nair), pp81-82
[92] ts 01.05.19 (Nair), p84
[93] ts 01.05.19 (Nair), p84
[94] ts 01.05.19 (Nair), p86

COMMENTS ON MEDICATION REGIME

81. Dr Silberstein considered that the medications prescribed to the deceased were "*consistent with contemporary medical practice*" and "*reasonable in all of the circumstances*".[95]

82. Keppra was the first medication prescribed to the deceased. A possible alternative would have been sodium valproate, marketed as Epilim.[96] However, Epilim was contraindicated in the deceased's case because it commonly causes significant weight gain and the deceased already had a very high BMI. In addition, Epilim requires regular monitoring by way of blood tests, which the deceased was known to be averse to. Further, Epilim can affect liver function and a blood test (performed under a general anaesthetic on 15 April 2014) had identified that one of the deceased's liver enzymes was already mildly elevated.[97,98]

83. The next medication introduced was lamotrigine. In Dr Silberstein's view this would have been a very useful; adjunct to Keppra because it has the lowest reported incidence of behavioural issues. Although it is not entirely clear, it appears that the deceased developed a rash and this medication had to be discontinued.[99]

84. Dr Silberstein agreed that topiramate was a good choice after lamotrigine was discontinued and the deceased's seizures were persisting. This medication would have been useful in controlling the deceased's tonic clonic seizures and it has the additional benefit (especially given the deceased's weight) of suppressing appetite.[100]

85. As noted, there is some evidence that the deceased's behaviour became aggressive since taking topiramate,[101] and although there is no clear evidence about when the deceased stopped taking it, he was clearly not taking topiramate in the lead up to his death.[102]

---

[95] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, paras 58 and 60
[96] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 60
[97] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 60
[98] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 19
[99] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 60
[100] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 60
[101] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair: Annexure K - Outpatient notes (18.02.15)
[102] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 60

86. The next medication suggested was the anti-epileptic, ethosuximide. Although there is no evidence that this medication was ever actually prescribed to the deceased, it would probably have been useful in controlling his absence seizures. In combination with other anti-epileptics it can have a synergistic effect, whereby tonic clonic seizures also improve.[103]

87. Dr Silberstein was asked whether any other treatments may have been useful for the deceased. In his report, Dr Silberstein canvassed several options, including ketogenic diet, vagus nerve stimulation, epilepsy surgery and seizure detection techniques (e.g.: dogs, monitors and smart watches). Dr Silberstein concluded, for various reasons, that none of these options would have altered the outcome in the deceased's case.[104]

88. On the basis of the evidence of Dr Silberstein, I am satisfied that the deceased's medication regime was appropriate and in accordance with contemporary medical practice.

89. The main issues compounding the management of the deceased's epilepsy appear to have been his failure to attend a number of important appointments, tests and reviews and the question of whether he was in fact fully compliant with his medication regime.[105,106]

90. Attempts to refine the deceased's medication regime to better control his epilepsy were adversely affected because the deceased's doctors had significant concerns as to whether he was fully compliant with his medication regime.[107] As it turned out, at least with respect to the deceased's non-compliance with his topiramate therapy, those concerns were well founded.

---

[103] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 60
[104] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 66
[105] ts 01.05.19 (Nair), p91
[106] ts 01.05.19 (Nair), p80
[107] ts 01.05.19 (Nair), p80

TOXICOLOGICAL FINDINGS[108]

91. Samples of the deceased's blood, body fluids and tissue were the subject of post mortem toxicological analysis. A report setting out the findings of that analysis was tendered in evidence as part of the Brief.[109] Professor Joyce (physician and clinical pharmacologist) was asked to comment on the toxicological results. He prepared a report and gave evidence at the inquest.[110]

Levetiracetam (Keppra)

92. Levetiracetam is an anti-epileptic medication marketed as Keppra. It was found at a concentration of 12mg/L in the deceased's blood. This was lower than would be expected in an adult weighing 95 kg taking 1,750 mg twice per day.[111]

93. At the time of his death, the deceased weighed 95 kg[112] and was prescribed 1,750 mg of levetiracetam twice daily. However, Professor Joyce noted that there was not enough information about the levels one would expect in a child of that weight on that dose.[113]

94. Professor Joyce considered that the level of levetiracetam detected in the deceased's system was not so low as to indicate non-compliance and that the deceased was at least partially compliant and possibly fully compliant with his levetiracetam therapy at the time of his death.[114]

Topiramate

95. Topiramate is an anti-epileptic medication used to control tonic and clonic seizures. It has the side effect of reducing appetite and thereby assisting weight loss. As the deceased's BMI was well above the 95% percentile for his age in January 2015, this would have been desirable.[115]

---

[108] Exhibit 1, Vol. 1, Tab 6.14, ChemCentre Toxicology Report
[109] Exhibit 1, Vol. 1, Tab 6.14, ChemCentre Toxicology Report
[110] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce & ts 30.04.19 (Prof. Joyce), pp46-56
[111] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 27
[112] Exhibit 1, Vol. 1, Tab 3, Post Mortem Report, p2
[113] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 27 and & ts 30.04.19 (Prof. Joyce), p50
[114] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 40 and & ts 30.04.19 (Prof. Joyce), p50
[115] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 31

96. At the time of the toxicological analysis by the ChemCentre, the limit of detection for topiramate in blood was 1 mg/L. That sensitivity was, however, good enough to have detected topiramate had it been present. Further, the test was able to detect a distinctive "*topiramate artefact*" in cases where topiramate was below the detection threshold.[116]

97. Neither topiramate, nor its artefact were detected in the deceased's system. Dispensing records indicate that if topiramate had been taken as directed, then the prescriptions dispensed on 14 January 2015, 2 February 2015 and 18 February 2015 would have expired on 10 March 2015, some 17 days prior to the deceased's death.[117]

98. Those factors, plus the fact that police failed to locate any topiramate at the deceased's family home after his death, led Professor Joyce and Dr Silberstein to conclude that the deceased was not taking topiramate in the time leading up to his death.[118,119]

Diazepam

99. Diazepam is a sedating drug which belongs to the benzodiazepine family. In the body, it is transformed into desmethyldiazepam and temazepam which share the sedating qualities of the parent drug.[120]

100. The levels of desmethyldiazepam and temazepam in the deceased's system were low meaning that:

> "*the most recent dose was only small, or that some time, possibly days, has passed since drug ingestion.*"[121]

101. The deceased visited his GP on 24 March 2015 and was prescribed fifty 5 mg diazepam tablets which were subsequently dispensed. The GP records show that the distributer was out of Valium plastic vials and tablets were given instead.[122,123]

---

[116] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 28
[117] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, paras 17 & 28
[118] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, paras 29 & 41 and ts 30.04.19 (Joyce), pp50-51
[119] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 63
[120] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 30
[121] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 30
[122] Exhibit 1, Vol. 2, Tab 7, Midland Gate Pharmacy
[123] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 44

102. According to Professor Joyce, one of the 5 mg tablets taken on 24 or 25 March 2015 would have accounted for the levels of diazepam detected by toxicological testing. Two or three tablets taken on 24 March 2015 would give a similar result.[124]

103. The level of diazepam found in the deceased's system did not indicate a significant overdose had been taken at any time.[125] Both Professor Joyce and Dr Silberstein were of the view that the diazepam found in the deceased's system had nothing to do with his death.[126,127] However, its presence is of concern for another reason.

104. There is limited evidence about why diazepam was prescribed to the deceased in the first place. After reviewing the deceased's medical records, Dr Silberstein observed:

> "*I couldn't find any reference to a decision having been made to change the acute seizure management from midazolam to diazepam or to prescribe diazepam tablets for perhaps – well as – as an additional medication. So no, it wasn't clear to me at what point that decision had been made or who had made it.*"[128]

105. Professor Joyce observed that the diazepam tablets seemed to have been prescribed from one general practice but that the deceased's medical records did not disclose why the medication had been prescribed.[129]

106. Records from the deceased's GP show that the instructions for the use of the diazepam tablets was: "*1 as required for seizure*".[130] In her statement, the deceased's father's defacto partner refers to the deceased being prescribed levetiracetam (Keppra) and then states:

> "*He's also prescribed diazepam to help with his sleeping. I think it's to help calm him because one of the side effects of Keppra is weight gain and aggression.*"[131]

---

[124] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 31 and ts 30.04.19 (Joyce), p51
[125] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 31 and ts 30.04.19 (Joyce), p51
[126] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 31 and ts 30.04.19 (Joyce), p51
[127] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 62 and ts 30.04.19 (Silberstein), p28
[128] ts 30.04.19 (Silberstein), p21
[129] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 43
[130] Exhibit 1, Vol. 2, Tab 8, Records - Helena Valley Medical Centre
[131] Exhibit 1, Vol. 1, Tab 6.25, Statement – Defacto of Deceased's Father, para 18

107. However, Dr Ghia said that in his experience, diazepam would not be prescribed for sleep or behavioural issues for children with epilepsy.[132]

108. Dr Silberstein stated that diazepam in tablet form has no role in acute seizure management because it is not absorbed quickly enough by mouth.[133] A form of diazepam was used for seizure control in the past, but this was administered rectally and except in unusual circumstances, has now been replaced by ampoules of midazolam in liquid form.[134]

109. Professor Joyce's evidence supported Dr Silberstein on this point and he noted that the instructions for use of the diazepam tablets were to take the tablets as needed. As Professor Joyce noted:

> "*This presumably could not refer to use in terminating seizures, because oral tablets would be ineffective for that purpose. It is therefore not clear whether diazepam was needed at all in the days between dispensing on 24th March and death early on 27th March. Finding, or not finding the drug in blood would not tell us whether it was being taken as needed.*"[135]

110. Dr Nair said that in 25 years of practice, he had never prescribed diazepam tablets to children.[136] With respect to the appropriateness of prescribing diazepam to a child, Dr Nair said:

> "*It's certainly not a medication we would go near straight up for a child. In paediatrics, particularly with children, if we had to use something like diazepam, it would probably be my third choice or fourth choice down the line. I would certainly not go near that kind of drug orally for a child because…the sedative effects…can be quite significant. And…because of the obesity, working out what the right dose is would be very difficult because a certain amount of the drug would sit in the fat tissue and stay in the system."* [137]

---

[132] ts 01.05.19 (Ghia), p151
[133] ts 30.04.19 (Silberstein), p20
[134] ts 30.04.19 (Silberstein), p20 and see also: ts 01.05.19 (Ghia), p151
[135] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 43
[136] ts 01.05.19 (Nair), pp87-88
[137] ts 01.05.19 (Nair), p93

111. The interim property receipt issued by police following a search of the deceased's family home on the day of his death (27 March 2015) records the seizure of a "*container of Antenex 5 mg Diazepam containing no tablets*".[138] Thus, it appears that the diazepam tablets dispensed in the deceased's name three days before his death had gone missing by the time of his death.

112. After referring to the level of diazepam found in the deceased's system, Professor Joyce noted that the deceased:

> "*…did not take the entire 50-tablet prescription, or even an appreciable portion of it.*"[139]

113. On the basis of the evidence before me, I find that diazepam was found in the deceased's system but that it played no part in his death.

114. However, I am unable to make a finding as to why the deceased was prescribed diazepam, or what happened to the 50 tablets of diazepam dispensed in the deceased's name on 24 March 2015.

Doxylamine

115. Doxylamine is an antihistamine that is found in such preparations as Mersyndol (where it is combined with paracetamol and codeine and used for pain relief) and Restavit (used for insomnia).[140] Although the sale of preparations containing codeine has now been restricted, at the time of the deceased's death, Mersyndol was available as an "over-the-counter" medication.[141]

116. A trace of doxylamine was detected in the deceased's blood[142] although there is no record of the deceased ever having being prescribed doxylamine in any form.[143] If the deceased had taken Mersyndol, this would have happened in the last few days before his death rather than the last few hours.[144]

---

[138] Exhibit 1, Vol. 1, Tab 6.8, Interim Property Receipt (27.03.15)
[139] Exhibit 1, Vol. 1, Tab 27, Report - Prof. Joyce, para 45
[140] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 54
[141] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 54
[142] Exhibit 1, Vol. 1, Tab 6.14, ChemCentre Report(Toxicology)
[143] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 63 and ts 30.04.19 (Silberstein), pp34-35
[144] ts 30.04.19 (Joyce), pp51-52

117. This is because doxylamine outlasts the other ingredients in Mersyndol, namely codeine and paracetamol, and neither substance was detected in the deceased's system.[145] If the deceased had taken Restavit, the level of doxylamine detected would indicate a dose taken days earlier.[146]

118. Other than to note that on the morning of his death, the deceased did not appear to go to sleep until after 3.30 am, I am unable to make a finding as to whether the deceased was given Restavit, or some similar formulation containing doxylamine with respect to insomnia.

119. Regardless of the reason why the deceased may have taken doxylamine (or the form he took it in), at the concentration that was found in the deceased's body, Professor Joyce confirmed it was of no toxicological importance. Further, the evidence is that doxylamine did not cause the deceased's death.[147,148]

120. On the basis of the evidence before me, I find that while doxylamine was found in the deceased's system it played no part in his death.

Methadone

121. Methadone is a Schedule 8 drug mainly used in the management of opioid addiction. It is an opioid which can have a sedating effect and was never prescribed to the deceased.[149]

122. Methadone was found in the deceased's liver at a concentration of 0.05 mg/L, but there was not enough in the deceased's blood to reach the test's level of detection.[150] Professor Joyce estimated that a total of about 5 mg of methadone was present in the deceased's system at the time of his death. He noted that this might represent 5 mg of methadone taken in the few hours before death, or a bigger dose taken earlier.[151]

---

[145] ts 30.04.19 (Joyce), pp51-52
[146] ts 30.04.19 (Joyce), pp51-52
[147] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 32; ts 30.04.19 (Joyce), pp51-52
[148] ts 30.04.19 (Silberstein), pp35
[149] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 35
[150] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 34
[151] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 34 and ts 30.04.19 (Joyce), pp51-52

123. In his report, Dr Silberstein referred to reported cases where urinalysis tests had falsely reported the presence of doxylamine as methadone.[152] In this case, methadone was detected in the deceased's liver by a method known as "*targeted mass spectrometry*".[153] This test is specific for methadone and would not have confused methadone for some other agent.[154]

124. As to the effect of the level of methadone found in the deceased's system, Professor Joyce said:

> "*Given as a single dose, to a child who was unaccustomed to taking opioid drugs, it would be a bit sedating and might be a bit nauseating. There is not enough to reach the detection threshold in the blood (around 0.01 mg/L), so there is little reason to believe that the methadone really did provoke the vomiting that led to the aspiration and no reason to suspect that it sedated him to the point of being unaware of aspiration.*"[155]

125. There is no explanation for why methadone should have been found in the deceased's system and the fact that it was found is very concerning.

126. There are perhaps three explanations for how methadone came to be in the deceased's system. Either the deceased:

i. was given methadone by a person or persons unknown;

ii. stumbled upon some methadone and took it deliberately; or

iii. he somehow took some methadone accidentally.

127. All of these possibilities are troubling. If the deceased was given methadone by somebody deliberately, then the mental competence of that person must necessarily be called into question. If the deceased somehow stumbled upon some methadone or took some accidentally, then the level of supervision the deceased was subject to at the relevant time must be seriously questioned.

---

[152] Exhibit 1, Vol. 2, Tab 12, Statement - Dr Silberstein, para 55 & ts 30.04.19 (Silberstein), p30
[153] Conversation between Mr Leigh Boyd, Chemist and Counsel Assisting (30.04.19)
[154] ts 30.04.19 (Joyce), pp49-50
[155] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 34

128. In an email to Counsel Assisting dated 4 May 2019, the deceased's father made reference to a report in the media that methadone had been found in the deceased's system. Apparently by way of explaining how the deceased came to have methadone in his system, the deceased's father stated:

> "*I used a empty methadone bottle empty too fill with water too give him* [the deceased] *panadeine fort, because the pathetic medication he was on hurt his tummy and his head he was in Helena Valley screaming Daddy please help me I brought the medication as we had no support too get too Doctors I could not afford another drink so I used what was in the car and a tap in the garden, for three days afterwards he was fine, his first autopsies never had this* (sic)."[156]

129. In a further email to the Court on 11 June 2019, the deceased's father referred to a newspaper report of the inquest into his son's death and amplified his remarks with respect to the issue of how methadone came to be in the deceased's system, stating:

> "*First and foremost* [the deceased] *was never given methadone by myself or any other person I know of a empty bottle was used too give him a coediene tablet because he was suffering a upset stomach this was on the Tuesday and Wednesday before his death and only after consulting with a Doctor* (sic)."[157]

130. Professor Joyce agreed that the presence of methadone in the deceased's system was of concern, but noted that incidental contamination would not have accounted for the toxicological finding, stating that methadone was:

> "*…not one of the drugs that can incidentally turn up in a bit of tissue because of small amounts of contamination around the home or something like that. Its presence means that…*[the deceased]*…has taken a little bit at some stage.*"[158]

---

[156] Email from deceased's father to Counsel Assisting (04.05.19)
[157] Email from deceased's father to Court (11.06.19)
[158] ts 30.04.19 (Joyce), p56

131. On the basis of the evidence before me, I find that while methadone was detected in the deceased's liver, it played no part in his death. I am unable to make findings about how and why methadone came to be in the deceased's system. I will, however, make an observation.

132. The presence of methadone in the deceased's system means that he took some before his death. This is very concerning and indicates that the deceased's father was struggling to care for the deceased. It also supports the proposition that the support being provided to the deceased's father, at that time, was inadequate.

Alcohol

133. Alcohol was not found in the deceased's blood, but a small amount was found in his bile.[159] In Professor Joyce's view, this was probably caused by post mortem microbial action and is therefore of no toxicological significance.[160]

Midazolam

134. Ampoules of liquid midazolam were prescribed to the deceased for management of prolonged seizures (i.e.: seizures lasting 5 minutes of more). This medication is administered bucally, by squeezing the ampoule onto the inside of the patient's cheek.[161]

135. Midazolam was not detected in the deceased's system in post mortem tests.[162]

136. As Dr Nair noted, records showed that in 2014, eight ampoules of midazolam were dispensed in the deceased's name.[163,164] This was of concern to Dr Nair, as he explained:

> "*The thing that concerned me greatly was…has he been using that eight – you know, has that eight vials of midazolam been used?*

---

[159] Exhibit 1, Vol. 1, Tab 6.14, ChemCentre Report (Toxicology)
[160] Exhibit 1, Vol. 2, Tab 11, Report - Prof. Joyce, para 34
[161] ts 30.04.19 (Silberstein), p20
[162] Exhibit 1, Vol. 1, Tab 6.14, ChemCentre Report(Toxicology)
[163] ts 01.05.19 (Nair), p71
[164] Exhibit 1, Vol. 2, Tab 13, Statement - Dr Nair: Annexure F-4, List from Dr Zhang's records

…Which would mean that you would have had to have called an ambulance, which would mean you would have had to attend the emergency department, but…I didn't see the emergency department attendances to match the midazolam."[165]

137. In the period January 2015 - March 2015, a further 14 ampoules of midazolam were dispensed in the deceased's name.[166] However, there is no record of the deceased attending an emergency department in 2015, except on the day of his death.[167,168]

138. With respect to the midazolam ampoules dispensed in deceased's name in 2015, Dr Nair agreed that the ampoules were either: being used to treat prolonged seizures the deceased was experiencing (without emergency department attendance); not being used at all; or were being used by someone other than the deceased.[169]

139. All of those scenarios were rightfully of concern to Dr Nair who noted that this form of midazolam had great potential to be abused, especially by way of intra-venous injection.[170]

140. It appears that on 27 March 2015 (the day of the deceased's death), a further 10 ampoules of midazolam were dispensed.[171,172] These ampoules were not recorded on the interim property receipt police issued after they searched the deceased's family home[173] and there is no evidence in the Brief as to why these ampoules were dispensed or what happened to them after the deceased's death.[174]

141. Given that midazolam was not found in the deceased's system during post mortem tests, this issue is outside the scope of the inquest and I am unable to take the matter any further.

---

[165] ts 01.05.19 (Nair), p69
[166] Exhibit 1, Vol.2, Tab 6, Pharmacy records - Northam Discount Drug Store
[167] Exhibit 1, Vol. 1, Tab 6.16, Northam Hospital notes (emergency department – 27.02.15)
[168] ts 01.05.19 (Nair), p71
[169] ts 01.05.19 (Nair), p72
[170] ts 01.05.19 (Nair), p72
[171] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 47
[172] Exhibit 1, Vol.2, Tab 5, Pharmacy records - Stewarts Savemor (sic) Pharmacy Northam
[173] Exhibit 1, Vol. 1, Tab 6.8, Interim Property Receipt (27.03.15)
[174] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 61

CHILD SAFETY ISSUES

Involvement with Disability Services Commission (DSC)

142. The deceased first had contact with the DSC on 3 August 2005 when he was referred by his then GP. In 2007, DSC services provided to the deceased related to socialisation, communication skills and behavioural issues. At around that time, the deceased was receiving occupational and speech therapy services at school because the deceased's home environment: "…*was deemed unsuitable and unsafe…for therapy work…*".[175]

143. According to DSC:

> "*Service provision to [the deceased's] family members was irregular due to the parent's complex and chronic needs impacted by their relationship, drug/alcohol use, mental health issues and criminal behaviours. The parents' lifestyles often impacted on the children's school attendance and eroded opportunities to provide services to* [the deceased] *and his brother…*"[176]

144. By 2009, the deceased and his father and brother had moved to Northam. DSC noted that "*service provision continued to be disrupted by the parents' behaviours*" and that the deceased's father had "…*started disengaging with the Local Coordination Service and requesting more support for* [the deceased's brother]".[177]

145. In 2011, DSC records show that the deceased's father began making complaints that his and his children's needs were not being addressed. It is not clear how those complaints were responded to and whether attempts were made to more positively engage with the deceased's father.[178]

146. At a meeting on 15 October 2014 between DSC and staff from the deceased's school, the deceased's father raised concerns about the deceased's increased seizures at home and at school and his medication regime. The deceased's father was advised to consult the deceased's doctors. [179]

---

[175] Exhibit 1, Vol 2, Tab 4, Service Provision Review, Disability Services Commission (28.12.16), p1
[176] Exhibit 1, Vol 2, Tab 4, Service Provision Review, Disability Services Commission (28.12.16), p2
[177] Exhibit 1, Vol 2, Tab 4, Service Provision Review, Disability Services Commission (28.12.16), pp2-3
[178] Exhibit 1, Vol 2, Tab 4, Service Provision Review, Disability Services Commission (28.12.16), p3
[179] Exhibit 1, Vol 2, Tab 4, Service Provision Review, Disability Services Commission (28.12.16), p3

147. It is therefore regrettable that in October 2014 the deceased did not attend his PMH paediatric clinic appointment and that his father cancelled his neurology clinic appointment.[180] These appointments offered golden opportunities for the concerns raised by the deceased's father to be addressed.

148. A further school meeting on 12 November 2014, the deceased's father sought help with his dental care for his sons, saying a local dental service could not assist because of their special needs. DSC reportedly assisted the deceased's father to access a disability dental service and with issues relating to housing and respite.

149. According to the DSC, on numerous occasions, Local Coordinators contacted the Department and reported concerns about the deceased and his brother.[181]

Department's legislative framework

150. In Western Australia, the Department has primary responsibility for child safety and wellbeing. It came into existence on 1 July 2017, when the functions of the former Department for Child Protection and Family Support were transferred to the newly created Department of Communities.[182]

151. The Department works closely with families whose children are at risk of harm or have experienced actual harm.[183] The Department is the agency responsible for the administration of the *Children and Community Services Act 2004 (WA)* (the Act). One of the objects of the Act is:

> "*to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely or unable to give, that protection and care.*"[184]

152. Provisions in Part 4 of the Act enable a child to be apprehended in circumstances where an authorised officer believes that a child is in need of protection.

---

[180] Exhibit 1, Vol. 1, Tab 6.18B, Report - Dr Ghia, para 7
[181] Exhibit 1, Vol 2, Tab 4, Service Provision Review, Disability Services Commission (28.12.16), p3
[182] See: https://www.dcp.wa.gov.au/Organisation/Pages/aboutus.aspx
[183] Letter, Ms J Tang, Asst. Director General, Service Delivery: Metropolitan Communities (17.04.19)
[184] Section 6(d), *Child and Community Services Act 2004 (WA)*

153. This is usually done by way of a warrant, but where the authorised officer believes there is an imminent and substantial risk to the child's wellbeing, this can be done without a warrant.[185]

154. The circumstances when a child is said to be "*in need of protection*" are set out in section 28 of the Act and relevantly include:

> "*the child has suffered, or is likely to suffer, harm as a result of:*
>
> *(i) the child's parents being unable to provide, or arrange the provision of, adequate care for the child; or*
>
> *(ii) the child's parents being unable to provide, or arrange the provision of, effective medical, therapeutic or other remedial treatment for the child.*"[186,187]

155. The Department conducts investigations into the safety and wellbeing of children. Although these investigations are now called Child Safety Investigations (CSI), at the relevant time, they were called Safety and Wellbeing Assessments (SWA). SWA (now CSI) are essentially investigations into complaints concerning child safety.[188,189]

156. In broad terms, at the conclusion of the SWA (CSI), the outcome is either "*substantiated harm*" or "*unsubstantiated harm*". Where the outcome is substantiated harm, options range from making arrangements for the child's safe care within the wider family to taking the child into care.[190]

157. As it did in the case of the deceased's family, at one time, the Department made referrals to the "*Strong Families Program*". The program was an across-government collaborative planning and co-ordination process for families with complex needs receiving services from a number of agencies. The aim of the program was to avoid duplication and to ensure there were no gaps in the services being delivered. The program was disbanded several years ago.[191]

---

[185] Sections 35 and 37, *Child and Community Services Act 2004 (WA)*
[186] Section 28(2)(d), *Child and Community Services Act 2004 (WA)*
[187] ts 01.05.19 (Trahanas), p101
[188] ts 01.05.19 (Trahanas), p 98
[189] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), pp2-3
[190] ts 01.05.19 (Trahanas), p 98
[191] ts 01.05.19 (Trahanas), p105

158. Where a family has significant needs and a number of agencies are involved, the Department may convene a Signs of Safety (SOS) meeting, where all relevant agencies involved in a family's care are brought together. A "*family map*", is created by pooling relevant information and is used to plan and coordinate service delivery.[192]

159. On at least one occasion an SOS meeting was held with respect to the deceased, but it is of concern that an SOS meeting did not occur in December 2014 when it was clearly warranted.[193]

Department's involvement with the deceased's family

160. The Department's extensive involvement with the deceased's family occurred against a backdrop of parental substance abuse, mental health issues and family and domestic violence. As the Department noted:

> "*All these risk factors heighted his* [the deceased's] *vulnerability (and his siblings) and had a potential impact on parental functioning.*"[194]

161. From 2002 to 2014, the deceased's safety and wellbeing was the subject of investigation by the Department on at least 13 occasions.[195] Further, between 2009 and 2014, the deceased was the subject of five SWA, although the outcome in each case was "*unsubstantiated harm*".[196]

162. The following examples of the Department's interactions with the deceased's family give an insight into the issues that confronted staff:

i. 03 May 2002: police contacted the Department after the deceased's parents were arrested for alleged possession of unlicensed firearms and a large quantity of prescription medication. The situation was resolved by the deceased's aunt assuming the deceased's care;[197]

---

[192] ts 01.05.19 (Trahanas), p107
[193] ts 01.05.19 (Trahanas), pp112-113
[194] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p10
[195] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p10
[196] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p1
[197] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p2

ii. 03 Nov 2005: concerns were expressed about the deceased's mother (who was pregnant at the time) using heroin and Valium. Further, the deceased's father's "*long history of drug use*" was noted.[198] The deceased's father subsequently admitted his drug use in a family meeting at King Edward Memorial Hospital on 25 November 2005;[199]

iii. 27 Sep 2006: police reported family and domestic violence incidents between the deceased's parents on 23 September 2006 and 24 September 2006;[200]

iv. 01 Feb 2007: the deceased's mother reported concerns about the deceased's father using illicit drugs and threatening self-harm and suicide in the presence of the deceased and his brother;[201]

v. 30 Jun 2007: the deceased's sister was apprehended by the Department and placed into care after being found unsupervised, in unsatisfactory conditions. Concerns were also expressed for the deceased and his brother because of ongoing substance abuse and domestic violence between their parents. In August 2007, the family began their engagement with the Strong Families Program and this continued until at least January 2008;[202]

vi. 27 Aug 2009: police advised they had raided the deceased's family home and found a loaded gun in a laundry basket within reach of the children as well as live ammunition "*in all the rooms and bedrooms of the house*";[203]

vii. 02 Sep 2009: a SWA was conducted because of escalating concerns about parental drug abuse, the deceased's mother's transiency and the findings made by the police during the raid on 27 August 2009. The outcome of the assessment was "*unsubstantiated harm*";[204]

---

[198] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p2
[199] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p3
[200] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p3
[201] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p3
[202] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p3
[203] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p5
[204] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p5

viii. 18 Feb 2010: a SOS meeting was held to review the progress of the deceased's parents in addressing areas of concern.[205] In December 2010, the deceased's father disclosed he had been using heroin and marijuana and had been diagnosed with epilepsy;[206]

ix. 08 Jul 2011: police reported a family violence incident between the deceased's parents;[207]

x. 19 Jan 2012: police found the deceased's father with syringes (one of which contained 30 ml of heroin) in his car. He admitted taking methylamphetamine but said the heroin was for the deceased's mother. Police located cannabis plants at the family home.[208] The family's case remained "*open*" until 29 February 2012 meaning a case manager was actively involved;[209]

xi. 24 Jun 2014: an incident was reported where the deceased's father grabbed the deceased's mother by the throat and she grabbed his hair and then threw a coffee cup and a chair at him.[210] The Department referred the deceased's mother to a family and domestic violence service and the deceased's father to a behaviour modification program for males who have been abusive to their intimate partner. There was no response or assessment of the children's safety and wellbeing;[211]

xii. 12 Dec 2014: police reported an incident of domestic and family violence which had occurred in the presence of the children. It appears that during a verbal argument, the deceased's father grabbed the deceased's mother by the throat and she hit the deceased's father on the head with a coffee cup.[212] The Department again referred the deceased's parents to behaviour and domestic and family violence support programs respectively and initiated a SWA.[213]

---

[205] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p5
[206] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p6
[207] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p6
[208] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p7
[209] ts 01.05.19 (Trahanas), p108
[210] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p7
[211] Letter, Ms J Tang, Assistant Director General, Department of Communities (09.05.19), p2
[212] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p7
[213] Letter, Ms J Tang, Assistant Director General, Department of Communities (09.05.19), p3

xiii. 12 Dec 2014 (continued): the concerns were framed around the potential for the children to be physically harmed by the violent interactions between their parents and also, that exposure to this type of behaviour could affect brain development and result in the children displaying aggressive behaviours or distress. Numerous unsuccessful attempts were made to speak with the deceased's mother. The deceased's father was spoken to on 12 January 2015.

The deceased's father told departmental workers that he had taken out a violence restraining order (VRO) against the deceased's mother and was adamant she would not be allowed in the family home. The deceased's father asked for help in managing the deceased's mother's contact with the children and was advised to seek support within his family network.

The SWA was completed on 26 February 2015 [despite the concerns reported by Ms Melvin on 17 December 2014 - see (xiv) below] and emotional harm and neglect were "*not substantiated*" as it was undetermined whether the deceased's reported aggressive behaviour related to his autism, his medical condition or was caused by him witnessing family and domestic violence incidents between his parents.

The safety plan put in place stated that the deceased's father would not allow the deceased's mother in the family home if she was under the influence of "*hard drugs*". There is no evidence of whether the deceased's father's capacity to implement this plan was ever reviewed and there is no record of any further assessment or action;[214]

xiv. 17 Dec 2014: Ms Melvin reported numerous safety concerns (see paragraph 61 of this Finding). A SWA was initiated and noted that during home visits, the deceased's father was not affected by illicit substances and had taken out a VRO against the deceased's mother to avoid further family violence incidents.[215]

[214] Letter, Ms J Tang, Assistant Director General, Department of Communities (09.05.19), p3
[215] Exhibit 1, Vol. 2, Tab 3, Service Provision Review - Mr Geddes (10.05.18), p8

xv. 17 Dec 2014 (continued): the outcome of the SWA was "*unsubstantiated harm*" and although an internal SOS mapping exercise was carried out, inexplicably a SOS meeting was not conducted;[216]

xvi. 3 Mar 2015: a referral was made to the Strong Families Program and an initial meeting was scheduled for 30 March 2015, however the deceased died on 27 March 2015.[217]

Assessment of Department's response

163. The Department was aware of drug use by the deceased's parents and further, that the deceased's primary caregiver (his father) had long term heroin dependency managed by the methadone program.[218]

164. The Department was also aware that the deceased's father had been diagnosed with depression, adult autism disorder and epilepsy.[219] Further, the Department knew that the enmeshed and volatile relationship between the deceased's parents was characterised by incidents of family violence.[220]

165. Mr Trahanas (Director of the Department's Perth District Office) noted that had the deceased and his brother been with their father when police found a syringe containing heroin in his car in January 2012, it is likely that they would have been taken into care. Mr Trahanas also agreed that a SOS meeting should have been conducted in December 2014 and could offer no explanation for why this had not occurred.[221]

166. Mr Trahanas said that had concerns around the deceased's compliance with medication persisted, then at some point, he might have been taken into care. On the basis of the deceased's case file, Mr Trahanas did not consider this point had been reached by the time of the deceased's death.[222]

---

[216] Exhibit 1, Vol. 2, Tab 3, Service Provision Review - Mr Geddes (10.05.18), p8
[217] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p8
[218] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p11
[219] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p10
[220] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p11
[221] ts 01.05.19 (Trahanas), pp 110 & 112-113
[222] ts 01.05.19 (Trahanas), p124

167. Mr Trahanas pointed to the successful interactions between the deceased's father and his case manager in Northam, who provided counselling, advocated on the deceased's father's behalf with government agencies and some financial assistance.[223]

168. When asked whether more could have been done to assist the deceased's father, Mr Trahanas properly acknowledged that:

> "*I think we can always do more…the earlier testimony* …[i.e.: of Dr Silberstein and Dr Nair]…*painted a picture of the children requiring a lot more attention perhaps, and so I wouldn't disagree with that. I think…*[the deceased's father]…*was, at times, floundering…and on those occasions, perhaps services could have been more readily provided.*
>
> *I think there were agencies with good intent, but whether that translated into the action that perhaps would have been meaningful, that's probably not as clear.*"[224]

169. In conceding that the Department's child safety response in the deceased's case should have been stronger, Mr Trahanas referred to the need for child care workers to consider the "*cumulative harm*" of the risks the deceased was being exposed to.[225,226]

170. In a departmental background paper called: "*Assessing and Responding to Cumulative Harm - September 2012*" (Paper), the term "*cumulative harm*" is said to refer to:

> "*…the effects of multiple adverse or harmful circumstances and events in a child's life. The persistent daily impact of these experiences can be profound and exponential, and diminish a child's sense of safety, stability and wellbeing.*"[227]

---

[223] ts 01.05.19 (Trahanas), p122
[224] ts 01.05.19 (Trahanas), p122
[225] ts 01.05.19 (Trahanas), p121 & 126
[226] See also: Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p10
[227] Exhibit 1, Vol. 2, Tab 3.1, Att. 1 to Service Provision Review - Mr Geddes (10.05.18), p2

171. The Paper encourages child protection workers to remain alert to the possibility of multiple adverse circumstances in all reports and to not just focus on the presenting issue. In this context, the history of departmental involvement is critical because it can reveal cumulative harm.[228]

172. According to the Paper, research has established that families who experience cumulative harm have multiple inter-linked problems (risk factors) including mental health problems, substance abuse and family violence. There may be an absence of protective factors and social isolation and enduring parental problems impacting on their ability to provide adequate care are present.[229]

173. This description would seem to fit the deceased's family at the relevant time and the conclusion that the deceased and his brother were the subject of cumulative harm seems open.

174. In terms of identifying when cumulative harm is present, the Paper relevantly notes:

> "*The types of reports received and the sources of information may provide indicators that the child is experiencing cumulative harm. When a case has previous reports either not investigated or not substantiated, inaccurate assumptions can be made that this case is not one of significant risk.*"[230]

175. As noted, in the deceased's case, the Department had investigated concerns about his safety and welfare on at least 13 occasions between 2002 and 2014. However, despite numerous SWA, harm or likelihood of harm was not substantiated on any occasion.[231]

176. In terms of assessing whether the deceased was the subject of cumulative harm, the Department conceded that although none of the SWA led to an outcome of substantiated harm:

> "*It is possible that these outcomes may have impacted on subsequent assessments. Assessments do not appear to have adopted a Cumulative Harm approach.*[232]

---

[228] Exhibit 1, Vol. 2, Tab 3.1, Att. 1 to Service Provision Review - Mr Geddes (10.05.18), p2
[229] Exhibit 1, Vol. 2, Tab 3.1, Att. 1 to Service Provision Review - Mr Geddes (10.05.18), p3
[230] Exhibit 1, Vol. 2, Tab 3.1, Att. 1 to Service Provision Review - Mr Geddes (10.05.18), p9
[231] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p10
[232] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p10

177. The Paper notes that the key to successfully working with a family where cumulative harm is detected is engagement with the child and their parents. As the paper notes:

> "*Parents' love for their children and motivation for them to be safe and well will usually be the primary reason parents engage with child and safety welfare services. Give parents space to talk about their hopes and dreams, worries and fears for their children. You will get rich information about the child and start to build a relationship with the parents around your shared aim of achieving the best outcomes for their child.*[233]

178. In the deceased's case, the proposition that earlier, more intensive intervention by the Department could have improved the deceased's situation is certainly attractive and was essentially conceded by Mr Trahanas.[234]

179. An investigation into the deceased's death was conducted by the Ombudsman Western Australia (OWA). In response to that investigation, the Department conceded that a stronger child protection response was warranted with respect to the deceased's family.[235,236]

180. On 1 June 2016, the OWA made a recommendation related to ensuring compliance with the SOS framework when assessing child safety and wellbeing. The OWA also recommended that all reasonable steps be taken to ensure compliance with sections of the Department's casework practice manual dealing with the proper assessment of the impact of alcohol/drug use issues and family and domestic violence on child safety and wellbeing.[237,238]

181. The Department says it has given effect to these recommendations by changes to its casework practice manual and by other initiatives[239] to which I will now briefly refer.

---

[233] Exhibit 1, Vol. 2, Tab 3.1, Att. 1 to Service Provision Review - Mr Geddes (10.05.18), p9
[234] ts 01.05.19 (Trahanas), p122
[235] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p8
[236] ts 01.05.19 (Trahanas), p126
[237] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p10
[238] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), p5
[239] Letter, Ms J Tang, Assistant Director General, Department of Communities (09.05.19), p2

Improvements since the deceased's death

182. In the first half of 2017, the Department established Intensive Family Support (IFS) teams to deliver services previously delivered through its Child Centred Family Support Service. IFS teams aim to work closely with families whose children are at imminent risk of being taken into care.[240]

183. The IFS service helps families use their strengths to develop strategies, skills and plans to keep children safe and prevent them coming into care. Monthly multidisciplinary case conferences are conducted to monitor progress.[241] Mr Trahanas agreed the deceased's family would have benefitted from the IFS service had it been available.[242]

184. In July 2017, the Department amended its casework practice manual when it introduced a system of shared case management.[243,244] This is said to have simplified and facilitated shared case management and co-working arrangements with families.[245,246]

185. The Department's casework practice manual has been amended to provide more specific guidance to child protection workers on how to conduct investigations into child safety and wellbeing concerns (chapter 2.2.2). Approval by a team leader is now required for completed outcome reports with caseworker recommendations addressing harm and care arrangement concerns.[247,248]

186. In addition, specific guidance has been added to the case practice manual (chapter 1.4.1) with respect to the impact on child safety and wellbeing of alcohol and substance abuse by the child's carers or significant others. This requires a SWA to be initiated when alcohol and/or other drugs are adversely affecting parental functioning.[249,250]

---

[240] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p11
[241] Exhibit 1, Vol. 2, Tab 3.1, Service Provision Review - Mr Geddes (10.05.18), p11
[242] ts 01.05.19 (Trahanas), p125
[243] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), p2
[244] Att. 4 to Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19)
[245] ts 01.05.19 (Trahanas), p128
[246] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), p2 & Att. 4
[247] ts 01.05.19 (Trahanas), p128
[248] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), pp2-3
[249] ts 01.05.19 (Trahanas), p128
[250] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), p2

187. Specific guidance has also been added to the case practice manual (chapter 2.3) with respect to the impact on children of family and domestic violence including "*emotional abuse*".[251] Workers have also been provided with tools relating to assessment, safety planning and engagement with perpetrators and the benefit of violence restraining orders.[252,253]

188. Since the deceased's death, the Department has undertaken a review of its Signs of Safety framework. A capability matrix has been developed to enable child protection workers to self-assess their decision making prior to discussing cases with their supervisors.[254]

189. The Department's SWA process was the subject of a review which began in 2018. The aim of the review was to promote better critical thinking, documented analysis of information about allegations and improved clarity and consistency of SWA's across all districts.[255]

190. The review was completed in 2019 and to better reflect the purpose of the investigation, recommended that SWA be renamed Child Safety Investigations (CSI) and that mandatory training be conducted to enhance the ability of staff to conduct CSI.[256]

191. That training, which began in May 2019, included a focus on the impact of harmful abuse and the child protection worker's role in responding to situations where a child is deemed to be in need of protection.[257]

192. The Department also provides workers professional development training with respect to family and domestic violence, alcohol and other drugs. In addition, team leaders have been provided with supervision and performance management training and from July 2019. Supervision training will occur monthly.[258]

---

[251] In 2016, s28(1) of the *Children and Community Services Act 2004 Act* (WA) was amended to include emotional abuse which is defined to include being exposed to family violence.
[252] ts 01.05.19 (Trahanas), p128
[253] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), pp1-2 and 3-4
[254] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), p2
[255] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), pp2-3
[256] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), p3
[257] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), p3
[258] Letter, Ms J Tang, Assistant Director General, Department of Communities (17.04.19), p4

EVENTS LEADING UP TO THE DECEASED'S DEATH

193. I now turn to the circumstances of the deceased's sudden and tragic death.

194. On 26 March 2015 at about 3.30 pm, the deceased reportedly had a tonic clonic seizure that lasted for three to four minutes.[259] At about 1.00 am on 27 March 2015, the deceased was at home with his family. He went into his father's bedroom and asked for a sandwich and his father got up and went with him into the lounge room. The father's defacto partner stayed in bed.[260]

195. At about 1.30 am, the deceased and his father were lying together talking about what the deceased wanted for Easter. The deceased also asked his father if he had to go to school. At about 3.30 am, the deceased's father got up and went to his own bed, leaving the deceased half asleep.[261,262]

196. At 7.30 am on 27 March 2015, the deceased's father woke and found the deceased lying face down on the floor near the toilet. The deceased's face was blue, his tongue was protruding from his mouth and his legs were purple, cold and stiff. The deceased's father began CPR and his partner called emergency services.[263,264,265]

197. Ambulance officers arrived and took over resuscitation efforts[266,267,268] and transported the deceased to Northam Hospital where he was declared deceased at 8.10 am on 27 March 2015.[269,270]

---

[259] Exhibit 1, Vol. 1, Tab 6.24, Statement - Deceased's Father, paras 17
[260] Exhibit 1, Vol. 1, Tab 6.25, Statement - Deceased's Father's Partner, paras 8-11 & 14
[261] Exhibit 1, Vol. 1, Tab 6.24, Statement - Deceased's Father, paras 13-16
[262] Exhibit 1, Vol. 1, Tab 6, Police investigation report, p9
[263] Exhibit 1, Vol. 1, Tab 6, Police investigation report, p9
[264] Exhibit 1, Vol. 1, Tab 6.25, Statement - Deceased's Father's Partner, paras 41 & 46
[265] Exhibit 1, Vol. 1, Tab 6.24, Statement - Deceased's Father, paras 1, 4-8 & 10
[266] Exhibit 1, Vol. 1, Tab 6.25, Statement - Deceased's Father's Partner, paras 50-51
[267] Exhibit 1, Vol. 1, Tab 6.24, Statement - Deceased's Father, para 12
[268] Exhibit 1, Vol. 1, Tab 6.6, St John Ambulance Patient Care Record (27.03.15)
[269] Exhibit 1, Vol. 1, Tab 6.5, Life extinct form (27.03.15)
[270] Exhibit 1, Vol. 1, Tab 6.16, Northam Hospital emergency department notes (27.03.15)

CAUSE AND MANNER OF DEATH

198. A post mortem examination of the deceased's body was conducted by a forensic pathologist (Dr White) on 1 April 2015. Dr White noted the deceased had a high BMI (38.1) and that his heart and other body organs were enlarged, consistent with his height and weight.[271]

199. Microscopic examination of the deceased's tissues confirmed evident aspiration in his lungs.[272] Neurological examination of the deceased's brain was unremarkable.[273]

200. Microbiological examination found the bacteria *Streptococcus dysgalactiae* in the deceased's lung tissue. Dr White noted that interpretation of this finding was difficult because:

> "*…no obvious infection was seen in the lungs or elsewhere."* [274]

201. Dr White observed that because of the position in which the deceased was found, an element of postural asphyxia contributing to his death could not be excluded.[275]

202. After considering all of the test results she had received and the findings of her post mortem examination, Dr White expressed the opinion that the cause of death was consistent with epileptic seizure with aspiration.[276]

203. I accept and adopt that conclusion.

204. I find that death occurred by Natural Causes.

205. On the basis of the evidence of Dr Silberstein[277] and Dr Nair[278], I conclude that the most likely explanation for the deceased's death is SUDEP.

---

[271] Exhibit 1, Vol. 1, Tab 3, Post mortem report
[272] Exhibit 1, Vol. 1, Tab 3, Post mortem report
[273] Exhibit 1, Vol. 1, Tab 4, Neuropathology report
[274] Exhibit 1, Vol. 1, Tab 3, Post mortem report, p1
[275] Exhibit 1, Vol. 1, Tab 3, Post mortem report, p1
[276] Exhibit 1, Vol. 1, Tab 3, Post mortem report, p1
[277] Exhibit 1, Vol. 2, Tab 12A, Report - Dr Silberstein, para 57 and ts 30.04.19 (Silberstein), p8
[278] ts 01.05.19 (Ghia), p151

CONCLUSION

206. Quite obviously, the deceased's tragic death has had a profound impact on his family. During the inquest, it was very clear to me that the deceased was dearly loved by his parents and that within the limitations imposed by the issues each of them battled with, they did what they could to nurture him.

207. The deceased's father, was not only responsible for the deceased's day-to-day care but at the same time, was caring for the deceased's brother who has autism. I cannot imagine how difficult this must have been.

208. The deceased's father was clearly struggling to cope with the circumstances he found himself in. Setting to one side his own substance abuse and medical issues, he had the care of two children with special needs. Clearly, he ought to have been provided with a greater level of support and assistance than he was.

209. The Department has properly conceded that its child safety response in this case should have been stronger. However, given my findings as to the cause and manner of the deceased's death, there is no suggestion that the outcome in this case would have been different had this occurred.

210. As I have noted, as a result of the deceased's death, the Department has made a number of changes to its policies and procedures aimed at improving the way it responds to the sorts of issues that impacted on the deceased's family. In addition, the Department has introduced an intensive family support service designed to provide families with children at risk of being taken into care with a greater level of support. The deceased and his family would have benefitted from this service had it been available at the relevant time.

211. The initiatives to which I have referred are clearly attempts by the Department to improve its ability to respond to significant issues impacting on child safety, such as alcohol and substance abuse by care-givers and domestic and family violence.

212. Given the changes that have been implemented by the Department since the deceased's death, I do not consider it appropriate for me to make any recommendations in this matter.

213. The death of a child is unspeakably sad and this is particularly so when, as here, that death occurs in unexpected circumstances. I can only hope that the changes the Department has made provide the deceased's parents, his family and his friends with some solace for their terrible loss.

M A G Jenkin
Coroner
12 June 2019