JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	Philip John Urquhart
HEARD	:	12 OCTOBER 2020
DELIVERED	:	4 JANUARY 2021
FILE NO/S	:	CORC 252 of 2018
DECEASED	:	BABY JDU

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Children and Community Services Act 2004 (WA)

Counsel Appearing:

Ms S Tyler appeared to assist the Coroner

Ms A Barter (Aboriginal Legal Service) appeared on behalf of the family

Ms T Chee (State Solicitor's Office) appeared on behalf of the Department of Communities, WA Country Health Service and Child and Adolescent Health Service

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Philip John Urquhart, Coroner, having investigated the death of a male child referred to as **Baby JDU** with an inquest held at Perth Coroner's Court, Court 85, Central Law Courts, 501 Hay Street, Perth, on 12 October 2020 find that the death of **Baby JDU** occurred on 5 March 2018 at Princess Margaret Hospital, from Scimitar syndrome in the following circumstances:*

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SUPPRESSION ORDER

Suppression of the deceased's name from publication and any evidence likely to lead to the child's identification.

The deceased is to be referred to as "Baby JDU".

INTRODUCTION

1. The deceased (Baby JDU) died on 5 March 2018 from Scimitar syndrome, a rare congenital disorder consisting of heart and lung malformations. He was 11 weeks old. At the time of his death, Baby JDU was in the care of the Chief Executive Officer (CEO) of the Department of Communities (the Department).[1]

2. Accordingly, immediately before his death, Baby JDU was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was therefore a "*reportable death*".[2]

3. In such circumstances, a coronial inquest is mandatory.[3] Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received from the Department while in that care.[4]

4. I held an inquest into Baby JDU's death at Perth on 12 October 2020. The following witnesses gave oral evidence:

    i. Dr Katherine Templeman (Director of Medical Services, Geraldton Regional Hospital);

    ii. Dr James Ramsay (Paediatric Cardiologist, Perth Children's Hospital); and

    iii. Mr Lindsay Hale (Assistant Director General for Regional and Remote Communities with the Department).

5. The documentary evidence at the inquest comprised of two volumes which were tendered as exhibit 1. An additional exhibit was provided by the Department after the inquest and it became exhibit 2.

6. The inquest focused on the involvement of the Department in Baby JDU's life and on the management of his medical conditions.

7. On the basis that it would be contrary to the public interest, the State Coroner made a suppression order with respect to Baby JDU's name on 19 June 2020, pursuant to section 49(1) of the *Coroners Act 1996* (WA). The terms of that order are set out on page 2.

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[1] Exhibit 1, Vol. 1, Report - Rachael Green, Department of Communities dated 6 February 2020, p 12
[2] Section 3, *Coroners Act 1996* (WA)
[3] Section 22(1)(a), *Coroners Act 1996* (WA)
[4] Section 25(3), *Coroners Act 1996* (WA)

MEDICAL ISSUES

Background

8. Baby JDU was born on 17 December 2017 at Geraldton Regional Hospital (GRH). He was 38 weeks plus 5 days gestation which was considered to be term. His birth weight was 2,720 grams. Shortly after his birth, Baby JDU developed respiratory distress and his oxygen levels dropped significantly. Respiratory support was commenced using a CPAP[5] machine and he was treated by the hospital's consultant paediatrician. A chest X-ray showed that Baby JDU's heart was on the right rather than left side of the chest cavity, suggesting dextrocardia (a rare congenital heart condition in which the heart points to the right).[6] When his respiratory distress continued to deteriorate, Baby JDU was transferred to Princess Margaret Hospital (PMH) by the Royal Flying Doctor Service on 18 December 2017.[7]

Diagnosis

9. Baby JDU was admitted to the neonatal intensive care unit at PMH. On 19 December 2017, an echocardiogram (ECG) revealed the following cardiac and pulmonary abnormalities: [8]

i. Scimitar syndrome (a congenital heart defect);

ii. right hemi anomalous pulmonary venous return (abnormal vein draining of the lung on the right side);

iii. congenital hypoplasia of both lungs (poorly formed, small lungs);

iv. bilateral pulmonary venous stenosis (narrowing of the pulmonary veins on both sides of the lung);

v. pulmonary hypertension (increased blood pressure in the lungs);

vi. severe right pulmonary artery hypoplasia (poorly formed, small pulmonary artery);

vii. systemic to pulmonary collateral artery (abnormal blood supply from the body's circulation to the lung); and

viii. Dextroposition (rotation of the heart to the right).

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[5] Continuous positive airway pressure
[6] Exhibit 1, Vol. 1, Tab 9, Report - Dr Katherine Templeman, WA Country Health Service dated 28 March 2018, p 1
[7] Exhibit 1, Vol. 1, Tab 9, Report - Dr Katherine Templeman, WA Country Health Service dated 28 March 2018, p 2; Exhibit 1, Vol. 2, Tab 3, RFDS In Flight Observation and Treatment Sheet dated 18 December 2017
[8] Exhibit 1, Vol. 1, Tab 8, Report - Dr James Ramsay, Child and Adolescent Health Service dated 3 April 2018, p 1; ts 12.10.20 (Dr Ramsay), pp 16-18

10. Dr Ramsay stated that the eight conditions diagnosed from the ECG were all connected.[9]

11. Dr Ramsay noted that only about one or two in every 100,000 babies have Scimitar syndrome with the most severe form developing in the first few weeks or months of life.[10]

12. A computerised tomography (CT) scan on 18 January 2018 also showed Baby JDU had a large left pulmonary artery and large left pulmonary veins (veins that transfer oxygenated blood from the lungs to the heart). The CT scan also showed evidence of increasing stenosis (narrowing that reduces blood flow) of the connection between the left pulmonary vein and the left atrium in Baby JDU's heart.[11]

13. Dr Ramsay also explained that the obstructions to Baby JDU's left pulmonary artery and pulmonary veins as found by the CT scan were most unusual. He stated that it was very uncommon to get a narrowing or obstruction on both sides of the veins, adding he had not ever seen that in Scimitar syndrome before.[12] It meant that "*all of those things would go along with this being a severe form and would increase the risk of mortality.*"[13]

Overview of treatment [14]

14. A team of five rotating paediatric cardiologists were involved with Baby JDU's care from the beginning of his admission to PMH with each one doing a week on-call.[15] In addition to cardiology reviews, the respiratory medical team at PMH were consulted and involved with his care.

15. On 20 December 2017, Baby JDU was extubated and respiratory support was slowly reduced.

16. As at 27 December 2017, Baby JDU had not gained any weight over the previous week. Another ECG was performed and it showed high pulmonary artery pressures. Cardiology reviews following this noted that surgery may need to be considered as Baby JDU required ongoing respiratory support. It

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[9] ts 12.10.20 (Dr Ramsay), p 29
[10] ts 12.10.20 (Dr Ramsay), p 17
[11] Exhibit 1, Vol. 1, Tab 8, Report - Dr James Ramsay, Child and Adolescent Health Service dated 3 April 2018, p 1
[12] ts 12.10.20 (Dr Ramsay), pp 29 and 31
[13] ts 12.10.20 (Dr Ramsay), p 30
[14] PMH medical records
[15] ts 12.10.20 (Dr Ramsay), p 15

was also suspected that he may have aspirated and antibiotics were commenced.

17. Baby JDU continued to require supplemental oxygen and he had ongoing increased respiratory rates. A trial of diuretic therapy was commenced on 12 January 2018. Baby JDU's oxygen levels continued to decrease and the supplementary oxygen and his respiratory rate remained raised.

18. Nevertheless, it appeared he was relatively stable and there was a plan for him to be moved from the neonatal intensive care unit to a general paediatric ward on 16 January 2018. However, the following day he had periods of respiratory distress and low oxygen levels and, as a result, he remained in the neonatal intensive care unit.

19. On 17 January 2018, an ECG showed changes suggestive of raised pulmonary artery pressure and some pulmonary venous obstruction of the left lung veins which the CT scan confirmed the following day.

20. On 18 January 2018, during transfer to radiology for the CT scan, Baby JDU's oxygen levels became very low and perfusion (decreased arterial blood flow) was poor. He was intubated and received fluid resuscitation. He was diagnosed as having a pulmonary hypertensive episode.

21. Baby JDU required ongoing intubation, sedation and ventilation at this time. As it was thought he may have had an aspiration pneumonia, he was treated with intravenous antibiotics. He was also commenced on Sildenafil to try and treat his pulmonary hypertension.

22. On 22 January 2018, Baby JDU was transferred from the neonatal intensive care unit to the paediatric intensive care unit. It was documented that the transfer was due to hospital bed status. It was also recorded that he was intolerant to his feeds and that he had a lumbar hemi vertebra at L1 (a type of vertical vertebral anomaly due to a lack of formation of one half of the vertical body).

23. On 24 January 2018, Baby JDU had a cardiac catheterisation (a procedure to treat cardiovascular conditions using a catheter). It was thought the pulmonary hypertension was responding to oxygen and nitrous oxide so the dosages of Sildenafil were increased. Baby JDU was able to be extubated on 27 January 2018, and he was commenced on CPAP high flow oxygen.

24. On 30 January 2018, Baby JDU was transferred to a general paediatrics ward. It was apparent that he was relatively stable at this point and a discharge was planned for early February. The plan was for him to be discharged home with supplemental oxygen to his foster carers.

25. However, in the early hours of 6 February 2018, Baby JDU was the subject of a Medical Emergency Team (MET) call for bradycardia (slow heart rate), hypoxia (low oxygen levels) and an increased breathing rate. He was transferred back to the paediatric intensive care unit in a very unwell state. An ECG showed severe obstruction to the left pulmonary venous return at the entry of the pulmonary veins to the left atrium. On that same day, urgent surgery was performed on the obstruction and platelets (blood cells that form clots to stop bleeding) and blood had to be administered during the procedure. The sternum was left open following the surgery and nitric oxide and Sildenafil given.

26. A post-operative ECG showed that Baby JDU's left heart chamber (left ventricle) was functioning satisfactorily, however the functioning of his right ventricle was greatly reduced. After the swelling of his heart subsided, Baby JDU's sternum was closed on 8 February 2018 and he was extubated a day later.

27. Notwithstanding the relative success of the surgery, Baby JDU remained very unwell. On 11 February 2018, he had a fever and intravenous antibiotics were commenced. On 13 February 2018, he developed abnormal cardiac rhythms with intermittent bursts of supraventricular tachycardia (abnormally fast heartbeat) and anti-arrhythmic medications were given. Over the next two days, Baby JDU had ongoing abnormal cardiac rhythms, low oxygen levels, high carbon dioxide levels and he was very irritable.

28. On 16 February 2018, Baby JDU was re-intubated as his condition had deteriorated further. It was noted that if Baby JDU continued to deteriorate, prolonged resuscitation would be futile and a meeting was scheduled to plan for that potential outcome.

29. On 17 February 2018, a meeting was held by treating doctors with Baby JDU's parents, his foster carers and staff from the Department. It was accepted by those medical staff caring for him that Baby JDU's condition was complex, although hope was still maintained that his problems may resolve in the short-term.

30. From 18 February 2018, Baby JDU was extubated onto high flow oxygen. Although he had ongoing arrhythmias (irregular heartbeats), his condition did appear to stabilise and it was anticipated he could be transferred to a general ward. That transfer was due on 23 February 2018, however he began having rapid respiratory and pulse rates. CPAP was commenced and Baby JDU remained in the paediatric intensive care unit.

31. On 26 February 2018, an ECG indicated ongoing pulmonary hypertension and the Sildenafil medication was further increased. Baby JDU was transitioned from CPAP to high flow oxygen. His pulmonary hypertension remained severe and he was placed on maximum medical management.

32. On 1 March 2018, due to ongoing concerns, a multi-disciplinary meeting with cardiologists, intensive care unit doctors and respiratory doctors was held. It was agreed by those in attendance that there were no further medical or surgical options available to Baby JDU that would improve his clinical situation. He had pulmonary hypertension with a very small right lung and a left lung with hypoplasia. No cardiac operation was going to improve his pulmonary hypertension and no ongoing respiratory support was going to provide long-term improvement.

33. On 2 March 2018, Baby JDU was transferred to a general ward with one-on-one nursing care. A meeting was planned by treating doctors for the following week with Baby JDU's family and staff from the Department to discuss a possible referral to palliative care.

34. On 5 March 2018, and before that meeting could be held, a MET call was initiated at about 7.00 am. This was because Baby JDU had poor perfusion and increased oxygen requirements. He required ventilation with a mask before he was commenced on CPAP. He was administered fluids and nitric oxide and transferred back to the paediatric intensive care unit. Notwithstanding this treatment, there was ongoing poor perfusion. A decision was made that Baby JDU should not be intubated as protracting the dying process with invasive respiratory support was not in his best interest. For the same reason it was decided not to perform CPR either. Baby JDU died at 9.50 am on 5 March 2018.

Comments on Baby JDU's medical care

35. Baby JDU was diagnosed with a very serious form of Scimitar syndrome with a number of connected complications. As stated by Dr Ramsay:[16]

> [Baby JDU] unfortunately had a severe form of Scimitar syndrome with bilateral lung hypoplasia and pulmonary venous obstruction. He received intensive care in the neonatal and paediatric intensive care units over most of his inpatient stay at PMH. He had a surgical procedure to open up his left pulmonary vein which appeared to be successful, but did not decrease his ongoing pulmonary hypertension, which was probably the main cause of his final deterioration.

36. When asked at the inquest as to his opinion of the standard of care Baby JDU received at PMH, Dr Ramsay responded, "*I think we offered* [Baby JDU] *a high level of care for a long time, and even in retrospect, I can't think of any other things we could or should have done*."[17]

37. Having carefully reviewed the evidence in this case, I am satisfied that Baby JDU received quality medical treatment at PMH from dedicated and committed hospital staff. Dealing with babies who are gravely ill must be a gruelling and emotionally exhausting experience.

THE DEPARTMENT'S INVOLVEMENT WITH BABY JDU

Contact with the Department by Baby JDU's family before his birth

38. The Department's involvement with Baby JDU's family began before he was born. He had three older siblings who were born in 2005, 2013 and early 2017. From 2013, these children were the subject of a number of Safety and Wellbeing Assessments by the Department. Between January and March 2017 each of these siblings were taken into provisional protection and care by the Department, pursuant to section 35 and section 37 of the *Children and Community Services Act 2004* (WA) (the Act).[18]

Provisional protection and care of Baby JDU [19]

39. On 24 October 2017, the Department's Murchison District Office (Murchison District) received a report that Baby JDU's mother was pregnant, not using antenatal care and had a drug dependency. Between that date and 12 December 2017, Murchison District made numerous attempts to contact Baby JDU's

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[16] Exhibit 1, Vol. 1, Tab 8, Report - Dr James Ramsay, Child and Adolescent Health Service dated 3 April 2018, p 1
[17] ts 12.10.20 (Dr Ramsay), p 29
[18] Exhibit 1, Vol. 1, Tab 11, Report - Rachel Green, Department of Communities dated 6 February 2020, pp 8-9
[19] Exhibit 1, Vol. 1, Tab 11, Report - Rachel Green, Department of Communities dated 6 February 2020

mother by telephone and through family members without success. This included a home visit to the last known address of Baby JDU's mother with a card left requesting she contact the Department.

40. On 7 November 2017, Murchison District completed an intake to a Safety and Wellbeing Assessment for the as yet unborn Baby JDU for anticipated physical abuse and neglect and for pre-birth planning.

41. On 20 November 2017, Murchison District determined that intervention action pursuant to section 35 of the Act would be taken with respect to Baby JDU at birth.

42. On 21 November 2017, Murchison District was contacted by GRH advising that Baby JDU's mother had been admitted the previous day with abdominal pain. It was confirmed that she had sought no antenatal care prior to this admission and had tested positive for polysubstance use. When discharged home that same day, Baby JDU's mother was referred by GRH to the Geraldton Regional Aboriginal Medical Service for ongoing antenatal care. However, she did not attend.

43. Despite repeated efforts to contact Baby JDU's mother through her relatives, the Department had no success prior to her presenting to GRH in labour on 17 December 2017.

44. On 19 December 2017, a warrant was granted by Geraldton Children's Court placing Baby JDU under the provisional protection and care of the CEO of the Department on the basis that Baby JDU would likely be living in circumstances that posed an unacceptable risk to his well-being.[20] On that same day, officers from Murchison District attended GRH and advised Baby JDU's mother of the warrant. Baby JDU's mother was not able to identify any family she would want Baby JDU to be placed with. Shortly after that meeting, Baby JDU's mother left GRH contrary to medical advice.

45. On 21 December 2017, Murchison District filed an application in Geraldton Children's Court for a protection order for a period of one year under section 51(1) of the Act for Baby JDU.

46. On 22 December 2017, the Murchison District approved a Provisional Care Plan for Baby JDU pursuant to section 39 of the Act.

47. On 23 December 2017, Geraldton Children's Court made an order that the Department file and serve a written proposal for Baby JDU by 13 February 2018. The application was adjourned to 20 February 2018.[21]

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[20] Section 35(1)(ca) of the *Children and Community Services Act 2004* (WA)
[21] On that date it was adjourned again to 17 April 2018

Comments on the Department's involvement with Baby JDU [22]

48. The Department's decision to apply for a provisional protection and care warrant for Baby JDU to take effect after his birth was appropriate in all of the circumstances. His three siblings were already the subject of provisional protection and care warrants and even without Baby JDU's medical complications, the application would have been appropriate.

49. On 2 January 2018, Murchison District sent a Care Arrangement Referral to a number of foster care agencies to find possible care options for Baby JDU. On 5 January 2018, one of those agencies contacted the Department with the names of two potential foster carers for Baby JDU and these foster carers commenced contact with him at PMH on 11 January 2018.

50. On 17 January 2018, alternate foster carers were allocated who had more experience caring for children with special needs. However, these foster carers were unable to take on Baby JDU's high care needs due to their commitments with other children in their family and the original foster carers were re-engaged to care for him.[23] The male foster carer was present at the time of Baby JDU's death.

51. Although the foster carers were advised by PMH of Baby JDU's rapidly deteriorating condition on 5 March 2018, it does not appear his parents were successfully contacted. Despite concerted efforts by PMH, the Department's Crisis Care Unit and WA Police, the Department was not able to contact Baby JDU's parents until the day after Baby JDU had died.

52. Although this was most unfortunate, I note that Baby JDU's condition deteriorated rapidly from approximately 7.00 am on 5 March 2018 and that Baby JDU's parents (who were not residing together at this point) were often difficult to contact.

53. At the conclusion of the inquest, Ms Barter, counsel for the family, stated in her closing submissions that the family felt "*they could have more support* [from the Department] *by way of transport and accommodation to see* [Baby JDU] *in Princess Margaret Hospital.*"[24] Ms Barter then clarified that this related to the paid accommodation provided to the family for only two nights in January 2018 and then for only a further two nights in February 2018 and the lack of transport options to PMH when family members were staying with a relative in Duncraig in January 2018.[25]

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[22] Exhibit 1, Vol. 1, Tab 11, Report - Rachel Green, Department of Communities dated 6 February 2020
[23] PMH Medical Records
[24] ts 12.10.20 (closing submissions by Ms Barter), p 56
[25] ts 12.10.20 (closing submissions by Ms Barter), pp 56-57

54. As Mr Hale was not able to shed any light on these matters during his evidence, the Department was invited to file written submissions with respect to the questions raised by the family. Those submissions were received by letter dated 23 October 2020 from Mr Hale with two attachments.[26]

55. Mr Hale contended that the Department was supportive of Baby JDU's parents having regular contact with him at PMH and had approved the Case Support Costs to support this which was pursuant to the Case Plan, the Provisional Care Plan and the Written Proposal for Child.[27]

56. On 22 January 2018, the Department approved Case Support Costs for Baby JDU's parents with respect to bus tickets (Geraldton to Perth) and two nights' accommodation in Perth to support contact with Baby JDU following his surgical procedure on 24 January 2018. It is apparent that following the two nights' accommodation, Baby JDU's parents resided at a relative's residence in Duncraig. Although that was less than ideal, I accept Mr Hale's contention that there was no Department record indicating that either of Baby JDU's parents requested that this accommodation support be extended.[28] Given the distance from Duncraig to PMH, Baby JDU's parents also encountered difficulties taking public transport to visit him.

57. On 16 February 2018, a Department officer contacted Baby JDU's parents to advise them of their son's deteriorating condition. This officer approved Case Support Costs for three nights' accommodation within walking distance of PMH to support an increased level of contact with Baby JDU at this time.[29] On that same day, the Department paid for the cost of fuel and accommodation for a family member to bring Baby JDU's three siblings to Perth so they could also visit him.[30]

58. On 26 February 2018, Baby JDU's mother attended the Department's Mirrabooka District Office (Mirrabooka District) requesting refuge accommodation as no refuge vacancies were available and Ronald McDonald House at PMH could not be used for emergency accommodation. The Department facilitated Baby JDU's mother's accommodation with her relative in Duncraig. Although it was arranged for Baby JDU's mother to contact Mirrabooka District the following day to reassess possible refuge accommodation, she made no further contact.[31] In his letter dated 23 October 2020, Mr Hale noted:[32]

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[26] Exhibit 2, The Department's Casework Practice Manual, Chapter 3.5.2: Case Management Costs - Case Support Costs and Chapter 3.5.6: Case Management Costs - Special Purpose Funding: Major, Extraordinary and Capital Costs
[27] Letter - Lindsay Hale to Counsel Assisting dated 23 October 2020, p 3
[28] Letter - Lindsay Hale to Counsel Assisting dated 23 October 2020, p 5
[29] Letter - Lindsay Hale to Counsel Assisting dated 23 October 2020, p 4
[30] Letter - Lindsay Hale to Counsel Assisting dated 23 October 2020, pp 4-5
[31] Letter - Lindsay Hale to Counsel Assisting dated 23 October 2020, p 4
[32] Letter - Lindsay Hale to Counsel Assisting dated 23 October 2020, pp 5-6

> [The Department's] *decision to provide* [Baby JDU's parents] *two nights' accommodation in January 2017* [sic] *and three nights' accommodation in February 2017* [sic] *was discretionary and, in part, based on their ability to access family support and accommodation in the Perth metropolitan area to maintain contact with* [Baby JDU], *pursuant to the Case Plan and Provisional Care Plan. Once contact with* [Baby JDU] *became unsupervised, pursuant to the written Proposal for Child,* [the Department] *provided Case Support Costs for food and bus passes to support* [Baby JDU's parents] *to attend PMH for contact with* [Baby JDU] *at their own discretion.*

59. I note that Mr Hale also explained that Baby JDU's parents did not seek an extension of the three nights' accommodation in February 2018.[33]

60. The Department does not have unlimited resources available to assist with the accommodation, transport and other expenses associated with family members visiting a child who is in hospital and under the Department's care.[34] Nevertheless, every reasonable effort should be made to financially assist immediate family members who wish to visit a gravely ill child who is hospitalised.

61. The Department approved Case Support Costs that came to $6,358.76 regarding Baby JDU. The amount provided with respect to accommodation and transport costs associated with visiting Baby JDU at PMH was $1,916.11.[35]

62. On the basis of the evidence contained in the brief and provided by Mr Hale in his oral evidence and in writing after the inquest, I am satisfied that the care, supervision and treatment provided to Baby JDU by the Department was of an acceptable standard. In addition, I am also satisfied that the Department's support with respect to accommodation and transport costs to Baby JDU's family so they could visit Baby JDU at PMH was of an acceptable standard.

CAUSE AND MANNER OF DEATH [36]

63. Dr Cooke, a forensic pathologist, conducted an external post mortem examination on Baby JDU's body on 12 March 2018.

64. The external examination showed changes of recent medical treatment, including a healing scar to the mid-region of the front of Baby JDU's chest. A review by the PMH medical file indicated a history of congenital abnormalities of the heart and lungs which included Scimitar syndrome, abnormal venous

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[33] Letter - Lindsay Hale to Counsel Assisting dated 23 October 2020, p 5
[34] Exhibit 2, The Department's Case Work Practise Manual - Chapter 3.5.2 Case Management Costs - Case Support Costs
[35] Letter - Lindsay Hale to Counsel Assisting dated 23 October 2020, pp 4-5
[36] Exhibit 1, Vol. 1, Tab 6A-C, Pathologist Recommendation for External Post Mortem, Post Mortem Report and Letter from Dr Cooke dated 12 March 2018

drainage of the lungs and underdeveloped right lung (complicated by increased blood pressure in both lungs).

65. At the conclusion of his investigations, and after a review of the PMH medical file, Dr Cooke expressed the opinion that the cause of death was Scimitar syndrome.

66. I accept and adopt the conclusion expressed by Dr Cooke as to the cause of Baby JDU's death.

67. I find that death occurred by way of natural causes.

CONCLUSION

68. Baby JDU was born with a very rare congenital disorder known as Scimitar syndrome. As this had developed in utero, it was a particularly severe abnormality. Although Scimitar syndrome is confined to complications with the right lung, Baby JDU also had unrelated complications to his left lung. Unfortunately, this increased an already high risk of mortality.

69. Despite a range of treatments, including surgery, Baby JDU succumbed to his complications and died on the morning of 5 March 2018 at the age of 11 weeks. Sadly, the entirety of his short life was in hospital, often in an intensive care unit.

70. Having carefully reviewed all of the available evidence in this matter, I am satisfied that the standard of care, supervision and treatment that Baby JDU received from the Department was appropriate. The care and treatment that Baby JDU received from the medical staff at PMH was of a very high order and it is a tragic regret that the prospect of Baby JDU's long-term survival was always going to be low, notwithstanding that level of care.

P J Urquhart
Coroner
4 January 2021

CORONERS COURT OF WESTERN AUSTRALIA