JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	12 DECEMBER 2022
DELIVERED	**:**	9 JANUARY 2023
FILE NO/S	**:**	CORC 1273 of 2021
DECEASED	**:**	Child F

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Markham assisted the Coroner.
Ms A Barter (ALS) appeared on behalf of the mother of Child F.
Mr E Cade (SSO) appeared on behalf of the WA Police Force, the WA Country Health Service and the Department of Communities.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Child F*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 12 December 2022, find that the identity of the deceased person was* ***Child F*** *and that death occurred on 18 June 2013 at 50 Nix Avenue, South Hedland, from respiratory failure in association with pneumonia in a child with metachromatic leukodystrophy in the following circumstances:*

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SUPPRESSION ORDER

The deceased's name is suppressed from publication. The deceased should be referred to as Child F in any external publication and no information should be published that might lead to the identification of the deceased or his siblings.

INTRODUCTION

1. Child F was only three years of age when he died on 18 June 2013. Tragically, in his very short life Child F had been the victim of physical abuse that had caused him serious injuries and led him to be taken into care. Then, while in care, he developed a rare neurogenetic disorder that led to his death. The small comfort that can be taken from this very sad case is that in the time after Child F was taken into care until his death, he was cared for in a loving home and given the best support and medical care that was available.

2. As Child F was a child in care when he died, his death was a reportable death under the *Coroners Act 1996* (WA) and a coronial inquest is mandatory. There was some confusion at the Department of Communities (Communities) as to whether the State Coroner was informed of the death in 2013, as police were involved in the matter. It was eventually established that the State Coroner had not been notified. The appropriate notification was eventually received on 7 May 2021 from the Deputy Director General of Community Services at the Department of Communities. The notification prompted a coronial investigation into Child F's death and the listing of an inquest, as required under the Act.[1]

3. I held the inquest on 12 December 2022 and I must now comment on Child F's care, treatment and supervision prior to his death.[2]

BACKGROUND

4. Child F was one of five half-siblings and I note his four half-siblings were all also taken into care.[3]

5. Child F's parents' relationship was marred by violence perpetrated by his father against his mother. On 28 July 2009, Carnarvon Police attended an incident of family and domestic violence during which it was reported that Child F's father had stabbed Child F's mother in the stomach with a kitchen knife and repeatedly struck her to the stomach while he was intoxicated. Child F's mother was 6 to 7 months' pregnant with Child F at the time. Child F's mother was seen to have scratches on her stomach. Child F's father claimed she had done it to herself. Child F's father was charged and released on protective bail conditions preventing him from having contact with Child F's mother and his older sister, who had reportedly also been assaulted.[4]

6. That day, Communities completed an intake for Child F's sister to have a Safety and Wellbeing Assessment for physical harm concerns, which were assessed as substantiated harm the following day. Child F's father was later convicted of physical abuse in relation to this child and sentenced to a six month community based order.[5] Communities also facilitated a referral of Child F's mother, who was

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[1] Exhibit 1, Tab 4.
[2] Pursuant to sections 3 and 22(1)(a) *Coroners Act* the death is deemed to be a 'death in care'.
[3] Exhibit 1, Tab 5.1.
[4] Exhibit 1, Tab 5.2.
[5] Exhibit 1, Tab 5.1.

pregnant with him, to a Perinatal Mental Health Service. She was walked to the service by Communities' staff and introduced to the mental health workers.[6]

7. There was another report of a domestic violence incident involving Child F's parents on 13 September 2009. The next day, Child F's mother started to take steps to try to arrange her own housing.[7]

8. Child F was born on 30 November 2009.[8]

9. On 11 December 2009, WA Police responded to another violent incident involving Child F's parents. Child F and one of his siblings were both reported to be present. There was a further incident on 31 December 2009 where it was reported both parents were intoxicated and Child F's father took Child F out into the street, followed by his mother, who began yelling at him. Police officers attended and, after assessing the situation, they were supportive of Child F's father retaining care of him, but he indicated he was unable to do so and requested Child F be returned to his mother. Child F's father was then issued with a 24-hour police order.[9]

10. On the same day, Communities completed an intake for Child F and his sibling to conduct initial inquiries for neglect concerns. There was another reported incident between Child F's parents on 18 January 2010, with no children present, and again on 7 February 2010. On 22 February 2010, there was another incident reported, during which both children were said to be present.[10]

11. Child F's parents' relationship ended sometime after March 2010 and it seems Child F's mother kept Child F and his sister with her and moved around the Murchison District. There was ongoing contact between Communities and relatives, with repeated concerns expressed about Child Fs mother's parenting and supervision of the children. On 25 August 2010, Communities' staff developed a safety plan with Child F's mother for Child F and his older sister to move into the care of their aunt in Karratha. This family care arrangement broke down on 30 August 2010, less than a week later. The children were then moved to another relative's household in Karratha as part of a new family care arrangement.[11]

12. In early September 2010, Child F's mother indicated that she was intending to collect the children from this relative. She was advised that Communities might be forced to take statutory action to take them into the care of the CEO. Child F's mother was referred to mental health services the next month.[12]

13. On 29 November 2010, Child F's mother told staff from Communities' Murchison District office that she intended to collect the children from the family care arrangement. An Aboriginal Practice Leader expressed some concern and suggested the children should remain in care rather than return to Child F's mother at that

[6] Exhibit 1, Tab 5.2.
[7] Exhibit 1, Tab 5.2.
[8] Exhibit 1, Tab 5.2.
[9] Exhibit 1, Tab 5.2.
[10] Exhibit 1, Tab 5.2.
[11] Exhibit 1, Tab 5.2.
[12] Exhibit 1, Tab 5.2.

time,[13] but it was noted that the children's maternal grandmother told Communities that Child F's mother seemed much more stable and was doing a lot better. It was ultimately determined by the District Director that the case had not reached the threshold to warrant intervention action. Accordingly, Child F's mother was permitted to collect the children and relocate them to Roebourne, with a plan for the Pilbara District staff to continue supporting her.[14]

14. Some concerns had been expressed by family members that Child F appeared developmentally delayed, noting he could not sit up properly or crawl at the age of nine months, but it does not seem that any developmental assessments were undertaken before he returned to his mother.[15]

15. On 3 December 2010, the Murchison District office recorded a supervision plan to request a co-worker from the Pilbara District to visit Child F's mother and discuss parenting and some concerns about her alcohol and drug use, as well as to offer support with parenting and make arrangements for a Signs of Safety mapping session between Child F's mother and service providers.[16]

16. On 9 December 2010, the children were brought in by their mother to the Mawarnkarra Health Service and were found to have diarrhoea and sores. Their mother said she had just picked them up from a relative's home, where they had not been cared for properly.[17]

17. On 14 December 2010, the Murchison District sent an email following up the earlier request for someone in the Pilbara District to conduct a home visit to 'check on the situation' and undertake a Signs of Safety mapping. A home visit was attempted the following day but was unsuccessful. However, staff from the Pilbara District's Roebourne did raise concerns even without the visit, as they were aware that Child F's mother's new partner had a history of serious domestic violence and assaults against his own children, although there had been no recent reports of any family and domestic violence between the two of them.[18]

CHILD F IS FORMALLY TAKEN INTO CARE

18. On 17 December 2010, the Mawarnkarra Health Service wrote to the Roebourne office of Communities regarding Child F's presentation to the service two days prior. He was assessed and found to have multiple bruises on his body, including one on his upper left ear, one to his left cheek and another on his sacrum. His mother was said to have given an 'inconsistent history' about how he had sustained in the injuries.[19]

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[13] T 19.
[14] T 20; Exhibit 1, Tab 5.2.
[15] Exhibit 1, Tab 7.
[16] Exhibit 1, Tab 5.2.
[17] Exhibit 1, Tab 5.2.
[18] Exhibit 1, Tab 5.2.
[19] Exhibit 1, Tab 5.2.

19. A week later, on 24 December 2010, Child F was brought in by his mother to Nickol Bay Hospital due to respiratory issues. He also presented with significant unexplained swelling to his legs, which his mother attributed to him rolling out of bed. He was subsequently transferred to Hedland Health Campus as it was identified that Child F had serious injuries to his legs and other parts of his body. The following day, Communities' Crisis Care Unit (CCU) received reports of physical and sexual harm concerns for Child F. He was said to have 20 fractures (some old and some new) and lacerations/fissures to his anal area that were suggestive of sexual harm. On the same day, CCU completed an intake to initial inquiry and progressed this to a Safety and Wellbeing Assessment. Police officers spoke to Child F's mother, who said she thought her new partner might be responsible for Child F's injuries, although she had not witnessed an assault.[20]

20. On 26 December 2010, Communities substantiated physical harm of Child F and brought him into provisional protection and care via s 37 of the *Children and Community Services Act 2004* (WA). Child F's mother and her new partner (not Child F's father, but the father of three of his step-siblings) were identified as persons alleged to possibly be responsible for the harm. On 27 December 2010, Child F was transferred to Princess Margaret Hospital (PMH) in Perth.[21]

21. On 29 December 2010, PMH staff provided Communities with a summary of Child F's injuries. He was noted to have multiple fractures, including: 5 x listed fractures in his left leg, 5 x listed fractures in his right leg, 1 x left parietal skull fracture, 1 x right arm and 2 x hip fractures. There was also noted to be lack of blood supply to the bones in his legs/feet, which could prevent his legs and feet from developing and cause him a lifelong disability. A report indicated that there could be no accidental explanation for the multiplicity of limb fractures of different ages that Child F had suffered.[22]

22. In addition, PMH advised that the Surgical Teams had also identified he had anal injuries. A Consultant Paediatrician suggested the mechanism of Child F's injuries was possibly due to penetrative injury to the anus, although it could also be consistent with severe constipation. Sexual harm was later substantiated by Communities through a Safety and Wellbeing Assessment, with the same persons alleged to be responsible.[23] WA Police investigated the allegations, including interviewing Child F's mother's new partner who denied causing Child F any harm. Ultimately, it was concluded there was insufficient evidence to lay any charges against any person.

23. Child F had to have plaster casts on both legs and his right arm and had ongoing review at the Orthopaedic Clinic until the casts were taken off on 23 January 2011.[24]

24. When Child F was discharged from hospital on 13 January 2011, he was not returned to his mother's care. Instead, Child F was discharged into the care of general foster

[20] Exhibit 1, Tab 5.1 and Tab 5.2.
[21] Exhibit 1, Tab 5.1.
[22] Exhibit 1, Tab 7.
[23] Exhibit 1, Tab 5.1 and Tab 5.2.
[24] Exhibit 1, Tab 5.2.

carers initially, and then the following day he was placed at ACS Country Services Weeriana Group Home until a more permanent placement could be found. He remained there for more than a year while consideration was given to an appropriate family carer. He would usually spend the day with the general foster carers and the nights at the group home due to his high care needs.

25. Both Child F's mother and father nominated possible permanent caregivers. After investigating the various options, on 1 April 2011, Child F was transferred into the care of Family Carer, Ms A. Ms A was the partner of Child F's biological father and had been nominated by him as an appropriate carer. Child F lived with Ms A along with his older sister, and he remained in Ms A's care until his death.[25]

26. By all accounts, Ms A was a wonderful carer for Child F. She provided a loving and supportive home to both children. Ms A described Child F as a previously "happy little boy"[26] who had been damaged and traumatised by things that had happened to him, so she gave him the best care she could to help him recover from these experiences. She recalled he was a loving little boy who "deserved to have somebody that loved him"[27] in return. Child F appeared to progress over time and was able to crawl, sit up on his own and say a few words. Unfortunately, he then began to regress again due to his illness, as explained below.[28]

27. On 8 February 2011, Child F was admitted to hospital following a seizure for the first time. Initially, it was felt it was likely a febrile seizure, which occurs commonly in children with a high temperature. Child F was reviewed at PMH and prescribed medications for when he had further episodes of fever, to try to prevent seizures from happening.[29]

28. A few days later, Communities' Pilbara District Office received a report detailing concerns in relation to Child F's developmental delays and emotional and psychological health and wellbeing. On 18 February 2011, Child F was assessed at Mawarnkarra Health Service and Dr Anand Deshmukh then wrote to the Pilbara District Office and advised that Child F was probably having generalised tonic seizures. Dr Deshmukh recommended Child F undergo an EEG to investigate whether he had a seizure disorder and recommended he commence on anti-convulsant medication to prevent further seizures.[30]

29. From April 2011, Ms A supported Child F to attend weekly therapy with a physiotherapist, occupational therapist and speech therapist due to significant gross motor, fine motor and language delays and behavioural responses consistent with childhood trauma. Child F was also engaging in sexual assault counselling.[31]

30. On 29 June 2011, Dr Anita Banks, a paediatrician at WACHS, provided a medical report outlining Child F's previous diagnoses of non-accidental injury and multiple

[25] Exhibit 1, Tab 5.1 and Tab 5.2.
[26] T 35.
[27] T 36.
[28] T 7.
[29] T 8.
[30] Exhibit 1, Tab 5.1.
[31] Exhibit 1, Tab 5.1.

fractures, global developmental delay, and other issues. Dr Banks later completed more testing with Child F, which determined that Child F met the criteria for global developmental delay and should be registered with the Disability Services Commission.[32]

31. On 7 October 2011, a Protection Order (Time Limited – 2 years) was granted in the Children's Court of Western Australia in relation to Child F. I should note at this stage that there was evidence put before me after the inquest that Child F's mother had suffered her own trauma in relation to Baby F's conception, but she still loved him and had tried to care for him, and when it became apparent she could not do so and keep him safe, she agreed to the Department taking over his care and provided her consent to the protection order being granted.[33]

32. Child F had another seizure on 26 October 2011. He was flown to PMH via the RFDS. He remained at PMH for several days before being discharged with a plan for follow up care from Hedland Health Campus. He was reviewed by a Paediatric Registrar on 21 November 2011 and a plan was made for his carer to be trained in the use of buccal midazolam in the event of another prolonged seizure.[34]

33. On 7 February 2012 an occupational therapist reported that Child F had regressed since having the seizures and he was no longer able to sit alone, feed himself or be bathed alone. Further special equipment was required to assist Ms A with Child F's care.[35]

34. Child F's father had been serving a prison term at the time the protection order was granted. He was released in February 2012 and moved in with Child F's carer and the children.[36]

35. Child F suffered a further rapid regression and was returned to PMH in mid-February 2012, where he was admitted and remained until mid-May 2012.[37]

DIAGNOSIS OF METACHROMATIC LEUKODYSTROPHY

36. During this long admission to PMH, Child F underwent surgery for removal of his gallbladder, which had shown evidence of polyps some time earlier.[38]

37. Child F was also noted to be exhibiting increased tone/stiffness in all four limbs, which raised the possibility of a severe neurological disorder being the cause of his seizures. He underwent a number of investigations and was ultimately diagnosed while still in hospital with Metachromatic Leukodystrophy (MLD), a rare neurodegenerative disorder which causes cells of the central nervous system to stop working. It is a genetic disorder that is inherited, and it was noted there was a

[32] Exhibit 1, Tab 5.1.
[33] Exhibit 1, Tab 5.1.
[34] Exhibit 1, Tab 5.1.
[35] Exhibit 1, Tab 5.1.
[36] Exhibit 1, Tab 5.1.
[37] Exhibit 1, Tab 5.1.
[38] Exhibit 1, Tab 5.1.

familial link between Child F's parents that increased his risk of inheriting the disorder. Some chromosome testing was done which showed a familial genetic link between Child F's parents. It was noted that Child F's condition was expected to deteriorate and his life expectancy was predicted to be drastically shortened. There is no treatment, and care was focussed around keeping him comfortable.[39]

38. Baby F had a percutaneous endoscopic gastrostomy (PEG) feeding tube inserted as he had difficulty swallowing due to the progression of the MLD and was at risk of aspiration.[40]

39. On 13 April 2012, the Department of Neurology at the Child and Adolescent Health Service wrote to Communities confirming that Child F had been diagnosed with MLD as well as severe neurodevelopmental disability ??, epilepsy and other issues. He was on various medications for his health conditions.[41]

40. In April 2012, discussions were had with Child F's mother, father and carer in relation to end of life planning for Child F. All were in support of Child F not suffering at the end of his life and for him to be allowed to pass away peacefully. A Care Plan was settled in June 2012, which set out Child F's significant health needs and end of life decisions.[42] It was noted in July 2012 that Child F's parents wanted him to die on country in Carnarvon if possible, although it was also noted that Carnarvon Hospital might not have the medical facilities needed to care for Child F and transporting him from Hedland Campus to Carnarvon was not ideal due to his decline in health. It was, therefore, decided that it was better to keep him in Hedland.[43]

41. Steps were taken in May 2012 to get approval from the Director General of Communities for a medical plan for Child F that made his care palliative. It was noted that his condition was unrelated to his background of abuse and was a genetic condition inherited from his parents.[44]

42. In August 2012 Communities' Pilbara District Office became aware that Child F's father was not coping with Child F's diagnoses and was using alcohol and drugs to excess and being violent in the home. Pilbara District Office staff conducted a home visit and offered supports.[45]

43. On 24 August 2012, the Pilbara District completed Child F's Quarterly Care Plan.[46]

44. On 6 September 2012, Communities' A/Director General approved a Submission for Termination of Life Support for Child F. As noted above, Child F's biological

[39] Exhibit 1, Tab 13.
[40] Exhibit 1, Tab 5.1.
[41] Exhibit 1, Tab 5.1.
[42] Exhibit 1, Tab 5.1.
[43] Exhibit 1, Tab 5.1.
[44] Exhibit 1, Tab 14 and 15.
[45] Exhibit 1, Tab 5.2.
[46] Exhibit 1, Tab 5.1.

parents had been consulted and they both supported the decision to terminate Child F's life support and not to resuscitate him.[47]

45. Between 5 and 9 November 2012, Child F, his carer, his father and his older sibling travelled to Perth for a holiday. During the trip there were two reported family domestic violence incidents perpetrated by Child F's father towards his partner. Police were contacted on the second occasion and Child F's father was taken to overnight accommodation. After returning home, a further incident was reported on 4 December 2012. Child F was not present during the incident.[48]

46. The Pilbara District completed an internal Signs of Safety mapping on 6 December 2012 in relation to Child F's father's use of family violence and the potential risk to the children. This escalated on 12 December 2012 when Child F's older sibling was seen to have a bruise under her left eye and reported Child F's father had hit her. Child F was in hospital at the time of the incident, having been admitted to Hedland Health Campus on 2 December 2012 for respite care. Discussions with Child F's carer indicated that his father was using drugs and alcohol daily.[49]

47. On 19 December 2012, the Pilbara District Office met with Child F's father to develop a plan. It was agreed he would see a drug and alcohol counsellor at Hedland Health Campus and engage with a Communities' male worker on a weekly basis. He also agreed to live elsewhere until mid-January 2013, although he would continue to have contact with Child F. A home visit the following day confirmed Child F's father had moved out of the house.[50]

48. There was another incident on 23 December 2012, when Child F was discharged from hospital. Child F's father was intoxicated that afternoon and he took Child F and wouldn't return him to Ms A. The police were notified and went to the house. They spoke with Child F's father and facilitated Child F's return to his carer. Child F's father was served with a 72 hour police order and conveyed to another address in South Hedland.[51]

49. Child F's father was arrested again and then bailed to the house where Child F was living with his carer in January 2013. Communities' staff visited the house on 7 February 2013 and noted Child F's father was aggressive and said he would not leave the house. Communities' staff took steps to have his bail address changed and he moved out of the house shortly after.[52]

50. In April 2013, Child F's health was deteriorating. He had suffered a number of colds and chest infections in the previous months. There was discussion about arranging some respite care for his carer to have a break. The Disability Services Commission became involved to assist with respite care solutions.[53]

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[47] Exhibit 1, Tab 5.1.
[48] Exhibit 1, Tab 5.2.
[49] Exhibit 1, Tab 5.2.
[50] Exhibit 1, Tab 5.2.
[51] Exhibit 1, Tab 5.2 and Tab 11.
[52] Exhibit 1, Tab 5.2.
[53] Exhibit 1, Tab 5.2.

51. Child F had a short hospital admission in late April 2013 for a chest infection and another admission in early May 2013. On 13 May 2013, hospital staff advised Child F's condition was deteriorating. He was administered morphine to relieve his pain and discomfort. By 20 May 2013, doctors were reporting that Child F had four to six weeks to live. It was planned for him to stay in hospital and spend time at home intermittently.[54] It was also agreed that in the event that Child F developed pneumonia, which was likely due to his swallowing issues, he would not be given antibiotics.[55]

52. On 7 June 2013, Communities approved a Special Needs Loading for his carer, Ms A, given his increasingly complex care needs and the burden this placed on Ms A to provide this high level of care, as well as caring for Child F's sister. The higher loading was backdated to April 2013.[56]

53. I note that Communities had facilitated supervised visits between Child F's mother and Child F, which were reasonably regular in 2011. However, the visits ceased in mid-2012 when Child F's mother became difficult to contact. Towards the end of 2012, Child F's mother reconnected with Communities and expressed a desire to recommence contact visits with Child F. She was able to have supervised contact with him on 5 February 2013, a couple of months prior to his death.[57]

54. Child F died on 18 June 2013 at his Family Carer's home in the arms of Ms A and in the presence of his father. Several other family members were also present in the home.[58]

CAUSE AND MANNER OF DEATH

55. As Child F's death was not reported to the State Coroner immediately after his death, no post mortem examination was conducted. According to the registered medical death certificate signed by Dr Anita Banks, the cause of death was attributed to:

> *Pneumonia (days), Respiratory Failure (days) and Metachromatic Leukodystrophy (1 year).*

56. I note that this certificate was given on a background of Child F's long history of illness and an understanding that he had a drastically reduced life expectancy due to his diagnosis of MLD, so his death was not sudden or unexpected, despite his young age. Dr Banks gave evidence at the inquest that the pneumonia and respiratory failure were properly described as complications of his MLD.[59] Dr Banks also clarified that his death was not linked to the inflicted injuries he had suffered.[60]

[54] Exhibit 1, Tab 5.1.
[55] T 13.
[56] Exhibit 1, Tab 5.2.
[57] Exhibit 1, Tab 5.1.
[58] Exhibit 1, Tab 5.1.
[59] T 13.
[60] T 11.

57. I am satisfied that Child F developed pneumonia, which led to respiratory failure, on a background of his diagnosed metachromatic leukodystrophy and following palliation. I am satisfied that his death occurred as a result of natural causes.

COMMENTS ON TREATMENT, SUPERVISION & CARE

58. I note that Communities was involved in Child F's care from a time prior to his birth, when his pregnant mother was assaulted. There were ongoing issues with his parents' ability to care for him and keep him safe, which led Communities to become involved in setting up an informal family carer arrangement. This continued until November 2010. In December 2010, Child F's mother took Child F and his older sister back into her care. Although it seems Communities' staff had some reservations, it was felt that there was insufficient evidence to commence proceedings to formally remove them from her care. I note there was no suggestion of any physical or sexual abuse being perpetrated against Child F up to that time, only allegations of possible neglect due to Child F's mother regularly leaving him with other relatives.

59. By the time Child F was hospitalised in late December, only weeks after being taken back by his mother, he had suffered more than 20 fractures and was considered to be at risk of being permanently disabled. He had also suffered significant psychological trauma. Child F's mother's new partner was considered the likely perpetrator, although he suggested his mother was involved. Both Child F's mother and her partner denied harming him. He was never returned to his mother's care. Instead, he was taken into the care of the CEO of Communities and eventually placed with a culturally appropriate family carer, the partner of his father.

60. Communities noted that prior to his death, Child F was very attached to his carer, Ms A, and whilst in her care he had made gains in his development, including responding to facial cues, sitting, crawling, reaching for objects, feeding himself and speaking a few words, prior to some regression due to his epileptic seizures.[61] It is also clear she had been protective of him and his older sibling when faced with violence from his father. Ms A was said to provide a stable, loving and safe living environment for Child F and his older sibling and both children thrived in the environment.[62] Dr Banks had a lot of contact with Ms A, and she described her as "an amazing carer"[63] who had a very big load placed on her with caring for Child F as his condition worsened, which she managed extremely well.

61. Ms A gave evidence at the inquest and it was very clear that she had loved Child F and had done everything in her power to make his life happy and comfortable, being well aware of the trauma and harm he had suffered before coming into her care. Dr Banks and the witnesses from Communities all spoke of Ms A's care of Child F in glowing terms and the community should be very grateful to her for selflessly taking on this big responsibility.

[61] Exhibit 1, Tab 5.2.
[62] Exhibit 1, Tab 5.3.
[63] T 10.

62. Sadly, Child F's death was not preventable. He developed a rare neurodegenerative disorder, as his parents both happened to carry the recessive gene responsible for MLD. Once the diagnosis was made, it was apparent nothing more could be done for Child F, other than to try and keep him as comfortable as possible in the last months of his short life. Ms A continued to care for him as his disease progressed and he slowly lost any ability to sit up, feed or bathe himself.

63. Dr Banks provided very dedicated care to Child F throughout this time, and it is clear that she and Ms A developed a very strong carer/doctor relationship. Dr Banks went out of her way to assist Ms A with the difficult task she had undertaken in managing Child F's increasingly complex health needs, along with input from other specialists and allied health professionals, and I am satisfied that together they managed to ensure that Baby F had as comfortable a life as was possible in the circumstances.

64. The evidence also indicates that there was a good relationship between Ms A and Child F's Case Manager from Communities. Efforts were made to provide Ms A with whatever support she required.

65. Overall, it is very clear that once Child F came into care, he was given very good treatment, care and supervision and all of the relevant people worked hard to make sure that the last period of his life was as comfortable as was possible. Although the decision to allow him back into his mother's care at the end of 2010 was, in hindsight, obviously the wrong decision, I accept there was nothing to predict the subsequent events. At the time the decision was made, there was no suggestion of any actual harm being caused to Child F, only allegations of neglect by his mother and it had appeared that she was in a more positive place. I also note the harm he suffered was not directly connected to his later death, although it is obviously a very serious matter.

66. Overall, I am satisfied the treatment, supervision and care provided by Communities to Child F was of a high standard.

67. Through her counsel, Child F's biological mother acknowledged after the inquest that the medical team and Communities team had looked after Baby F well and she also had no concerns about any of the circumstances surrounding his death. Indeed, she expressed her thanks to these agencies for what they did to care for her child after his terminal diagnosis.

68. In terms of the issue of failing to report Child F's death immediately, I heard evidence from Amber Fabry from Communities that steps have been taken by Communities since 2018 to ensure that Communities reports the death of any child in the care of the CEO to the Coroner, through the establishment of a Central Review Team (which is now part of the Specialist Child Protection Unit) and liaison with the Ombudsman, as well as other processes. I note that Ms Fabry also indicated that Communities would welcome the opportunity to meet with the Principal Registrar of the Coroners Court to discuss opportunities to further strengthen the collaborative processes between the two agencies, which I am confident can be facilitated.

CONCLUSION

69. Child F's story is a heartbreaking one. He suffered a lot of pain and trauma at a very young age, and just when he had finally found a safe and happy home, he was diagnosed with a terminal illness. His early death was expected once he received that diagnosis, with most children not living beyond the age of 5 years once diagnosed. All efforts were made by everyone involved to provide Child F with the best care possible, knowing that his early death was inevitable. Ms A and Dr Banks in particular can be credited with giving him the best life possible in the circumstances.

S H Linton
Deputy State Coroner
9 January 2023