JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	26 - 28 SEPTEMBER 2023
DELIVERED	**:**	10 NOVEMBER 2023
FILE NO/S	**:**	CORC 40 of 2019
DECEASED	**:**	CHILD ML

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S. Markham appeared to assist the coroner.

Ms P. Femia (State Solicitor's Office) appeared for the Department of Communities, and the Western Australian Police Force.

Ms R. Panetta (Panetta McGrath) appeared for Dr Barbara Ley.

SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make the following order pursuant to section 49(1)(b) of the *Coroners Act 1996* (WA): There be no reporting or publication of the deceased's name and/or any evidence likely to lead to the child's identification. The deceased is to be referred to as "Child ML".

Order made by: MAG Jenkin, Coroner (26.09.23)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of a female child referred to as ***Child ML*** *with an inquest held at Bunbury Coroner's Court, 3 Stephen Street, Bunbury, on 26 - 28 September 2023 find that the death of* ***Child ML*** *occurred on 24 February 2019 at a home in Australind, from pneumonia complicating a viral respiratory illness with acute combined drug effect in a young girl with cerebral palsy, recurrent aspiration, and chronic seizure disorder in the following circumstances:*

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INTRODUCTION

1. Child ML died from pneumonia complicating a viral respiratory illness with acute combined drug effect in a young girl with cerebral palsy, recurrent aspiration, and chronic seizure disorder on 24 February 2019. She was seven years of age.[1,2]

2. At the time of her death, Child ML was in the care of the Department of Communities (the Department).[3] Accordingly, immediately before her death, Child ML was a "*person held in care*" and her death was therefore a "*reportable death*".[4] In these circumstances, a coronial inquest is mandatory,[5] and where, as here, the death is of a person in care, I must comment on the quality of supervision, treatment and care the person received.[6]

3. The documentary evidence adduced at the inquest consisted of one volume, and the inquest focused on the involvement of the Department in Child ML's care, and the circumstances of her death. The following witnesses gave evidence at the inquest:

a. Ms A (Child ML's mother);
b. Mr C (Ms A's support person and husband of Mrs C);
c. Mrs C (Ms A's support person and wife of Mr C);
d. Dr Barbara Ley (Child ML's paediatrician);
e. Constable Michelle Reid (Investigating police officer);
f. Ms Joanne Haworth (Former investigating police officer);
g. Ms B (Child ML's carer);
h. Ms Joanne McDonald, (Caseworker, Department of Communities);
i. Dr Jodi White (Forensic pathologist);
j. Ms Hellen Hall (Team Leader, Bunbury, Department of Communities);
k. Professor David Joyce (Physician and toxicologist);
l. Detective Sergeant Gareth Reed (Bunbury Detectives Office);
m. Inspector David Gorton (WA Police Force); and
n. Mr Brendan Mooney (Department of Communities).[7]

[1] Exhibit 1, Tab 3, Life Extinct Form (24.02.19)
[2] Exhibit 1, Tab 4.1, Supplementary Post Mortem Report (03.06.22)
[3] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19)
[4] Section 3, *Coroners Act 1996* (WA)
[5] Section 22(1)(a), *Coroners Act 1996* (WA)
[6] Section 25(3), *Coroners Act 1996* (WA)
[7] Mr Mooney is the Department's Regional Executive Director, South West

4. On the basis that it would be contrary to the public interest, the State Coroner made a non-publication order with respect to the deceased's name on 30 June 2023. I varied that order on 26 September 2023 to provide that the deceased should be referred to as "Child ML". The terms of my order are set out on the cover page of this finding.[8]

5. Child ML's name was used during the inquest, but to ensure her identity remains protected, I have chosen to refer to Child ML's mother as "Ms A", her carer as "Ms B", and Ms A's support persons as Mrs C, and Mr C in this finding. No disrespect is intended to any person.

CHILD ML

Overview and medical issues[9,10,11,12,13,14,15,16,17,18]

6. Child ML and her twin sister were born at 28 week's gestation on 13 July 2011. Child ML also had an older brother, and her parents separated soon after she was born. Child ML was described as a beautiful little girl, who had a warm and engaging smile. Although Child ML was non-verbal, she was able to indicate pleasure by way of sounds and gestures, and she clearly enjoyed being with her carer and her mother and their respective families.

7. Child ML was diagnosed with spastic quadriplegia,[19] a severe form of cerebral palsy that causes jerking movements and stiffness in the limbs. Her gross motor functioning was assessed as "*Level 5*", and she was unable to control her head, trunk and limbs. According to Child ML's mother (Ms A), Child ML "*was given a life expectancy of three to five years from her birth*".[20]

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[8] Section 49(1), *Coroners Act 1996* (WA)
[9] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), paras 3-7 and ts 26.09.23 (Ms A), pp9-13
[10] Exhibit 1, Tab 1, P100 - Report of Death(01.06.19)
[11] Exhibit 1, Tab 2, P98 - Mortuary Admission Form (24.02.19)
[12] Exhibit 1, Tab 8.1, Report - Const. M Reid (01.06.19), p3
[13] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19), pp1 & 11-12
[14] Exhibit 1, Tab 19, Report - Dr B Ley, Bunbury Hospital (05.03.19) and ts 26.09.23 (Ley), pp81-85
[15] Exhibit 1, Tab 27, Report - Dr B Ley, Bunbury Hospital (14.09.23)
[16] Exhibit 1, Tab 12, Statement - Ms B (29.03.19), paras 9-29 and ts 27.09.23 (Ms B), pp139-167
[17] Exhibit 1, Tab 16.1, Report - Ms J McDonald (27.02.19)
[18] See also : Exhibit 1, Tab 21, Student Health Care Management & Emergency Response Plan
[19] Specifically, Child ML had spastic quadriplegia ex 28/40 with twin-to-twin transfusion
[20] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), para 7 and see also: ts 26.09.23 (Ley), p96

8. Child ML was also diagnosed with a seizure disorder, which was relatively well controlled, and she had chronic lung disease. She also experienced bilateral hip dislocations and foot deformities, and as a result she "*had no ability to walk at any stage*" and was confined to a wheelchair.[21] In addition, Child ML's hands were routinely splinted in an effort to prevent permanent disfigurement.

9. Due to her medical conditions, Child ML had very complex needs, and required 24-hour supervision and care. Child ML did not have a "*safe swallow or gag reflex*" and was unable to protect her airways, or safely consume food or drink orally. As a result, Child ML was eventually fed by means of a percutaneous endoscopic jejunostomy tube (PEJ tube), which passed through her abdominal wall into her jejunum.[22]

10. Plastic bags containing nutrient rich fluid were connected to Child ML's PEJ tube by means of a pump which ran continuously The feeding bags were provided by the Perth Children's Hospital (PCH), where Child ML was reviewed every six months. To facilitate Child ML's feeds, both Ms A, and Child ML's foster carer (Ms B) had feeding pumps in their homes.[23]

11. In an attempt to reduce the risk of aspiration, Child ML also had a tube which drained bile. Child ML also needed to be repositioned regularly (including during the night) to reduce the risk of aspiration and pneumonia. Ms B had supplemental oxygen, and a machine she used to suction secretions from Child ML's mouth. In her statement to police, Ms B described Child ML's care needs in these terms:

> On a daily basis I would provide and assist with the following: feeding and hydration, oral suctioning, postural repositioning, adjusting her foot orthotics, numerous nappy changes, bathing and hygiene, physical activity when out of her wheelchair, toileting, dressing and grooming.[24]

[21] Exhibit 1, Tab 12, Statement - Ms B (29.03.19), para 19
[22] Exhibit 1, Tab 12, Statement - Ms B (29.03.19), paras 10-16
[23] Exhibit 1, Tab 20, Perth Children's Hospital - Nutrition Care for Child ML (07.02.19)
[24] Exhibit 1, Tab 12, Statement - Ms B (29.03.19), para 21

12. When being transported by car, Child ML required a wheelchair accessible vehicle, and Ms B used a hoist to transfer Child ML from her wheelchair into bed and vice versa. Ms B also had equipment to assist with showering and bathing Child ML, who required full assistance with dressing.

13. In addition to her complex daily care needs, Child ML also had a very extensive medication regime, and she took numerous prescription medications including: clonazepam, gabapentin, baclofen, and sodium valproate. These medications were administered by means of a syringe into an extension of Child ML's PEJ tube, with tablets or capsules being crushed up and dissolved in water first.[25]

14. I note that on 3 April 2018, Child ML's caseworker and other departmental staff met to review Child ML's "*not for resuscitation*" order (NFR). The NFR, which was supported by Ms A, provided that Child ML was not to be placed on a ventilator, or resuscitated in the event of a respiratory arrest.[26]

15. At the conclusion of the meeting, participants decided that documentation should be prepared so that Child ML's NFR could be approved, and on 13 April 2018, the CEO of the Department signed a briefing note approving the NFR.[27]

16. As can be seen, Child ML was a child with a number of serious medical conditions and she had very complex care needs. Child ML required a consistent high level of supervision and care, and as I will explain, this proved to be beyond the personal and social resources of Child ML's mother, Ms A.

[25] ts 26.09.23 (Ms A), p31 and ts 27.09.23 (Ms B), pp159-161
[26] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), paras 26-27
[27] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), paras 26-27

THE DEPARTMENT'S INVOLVEMENT IN CHILD ML's CARE

Concerns for Child ML's welfare[28,29]

17. Between 2013 and 2016, the Department received numerous reports of concern relating to the safety and welfare of Child ML and her siblings. On several occasions, Child ML's mother, Ms A, was reported to be using methylamphetamine, and a variety of neglect and welfare concerns were also reported by members of the public, the police, and clinical staff at Bunbury Regional Hospital (BRH).

18. Key aspects of Child ML's safety, wellbeing and management include:

a. *8 July 2013*: family members alleged Ms A was using illicit drugs, her children were unclean, and Child ML was not receiving required therapies. After contacting various agencies, the Department assessed the claims as "*malicious*";

b. *9 December 2013*: a member of the public alleged Ms A was using methylamphetamine daily, and was in a relationship with a known drug-user.

Child ML was also reportedly being over-fed causing her feeding tube to block. However, no action was taken because Ms A "*was engaging with multiple agencies at this time*";

c. *6 February 2014*: police reported neglect concerns after attending premises where Ms A and her children were located. The Department investigated and found "*no concerns*";

d. *6 July 2015*: BRH advised Child ML had presented on three occasions in the past three months with vomiting and dehydration, and had missed numerous appointments. There were also concerns that Ms A had been misusing Child ML's diazepam and clonazepam;[30]

e. *10 July 2015*: police advised they had responded to a domestic violence incident, and served a police order on Ms A's partner;[31]

[28] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19), pp2-6
[29] See also: Exhibit 1, Tab 14, Department of Communities - Child Death Notification (25.02.19)
[30] See also: ts 27.09.23 (Ms B), pp147-149 and ts 27.09.23 (McDonald), pp181-182
[31] Exhibit 1, Tab 18, Family & Domestic Violence Report (IR) 100715 1350 14888 (10.07.15)

f. *27 July 2015*: BRH advised that Child ML had missed several paediatrician appointments, and that Ms A had been requesting additional prescriptions for diazepam and clonazepam, suggesting misuse.

Child ML also had a rash on her face which was believed to have been caused by her being left to lie in her own vomit;

g. *28 July 2015*: when interviewed, Ms A gave various explanations for having missed appointments, and asking for additional prescriptions. The Department closed their investigation, finding "*no concerns*";

h. *8 December 2015*: a member of the public reported that Ms A was using/dealing illicit drugs, and had told another person she gave Child ML double doses of diazepam so Child ML would "*sleep for long periods of time*".

During a home visit on 22 December 2015, Ms A denied using or dealing in illicit drugs, and when observed, Child ML and her sister were assessed as having "*presented well*";

i. *4 January 2016*: the Disability Services Commission (DSC) advised that their repeated attempts to contact Ms A had failed, and that when interviewed by police about her partner's drug use, Ms A had "*minimised the issue*" and any potential effect his drug use may be having on her children;[32]

j. *2 March 2017*: BRH reported that Child ML had been admitted on 21 February 2017, with severe weight loss and dehydration. There were also concerns about Ms A's drug use, and her interactions with medical staff;[33][34]

k. *20 March 2017 - 19 April 2017*: Ms A was required to undergo regular urinalysis to check for illicit drug use. She tested positive for methylamphetamine on three occasions, and either tested negative (or failed to attend for testing) on a further eight occasions;

[32] See also: ts 27.09.23 (McDonald), p172
[33] ts 26.09.23 (Ms A), pp13-16
[34] Exhibit 1, Tab 27, Report - Dr B Ley, Bunbury Hospital (14.09.23), pp2-4

l. *14 & 28 March 2017*: the Department convened "*signs of safety meetings*" with family members and service providers. A safety plan was prepared requiring that: Child ML attended school daily; attended all appointments; and that Ms A agreed to submit to urinalysis to monitor her illicit drug use. Child ML was discharged into Ms A's care on 5 April 2017;[35]

n. *7 April 2017*: at about 8.00 am on 7 April 2017, Ms A contacted BRH to advise that Child ML was vomiting and had diarrhoea. Following repeated requests from Child ML's caseworker and BRH staff, Child ML was eventually brought to BRH at 5.30 pm, and diagnosed with very high levels of sodium In her blood (hypernatremia);

o. *13 April 2017*: a signs of safety meeting was held with family members, health professionals and DSC staff. The meeting discussed: Ms A's illicit drug use; her failed urinalysis tests; her financial issues; and her delay in taking Child ML to BRH. It was decided it was unsafe for Child ML to be discharged into Ms A's sole care until "*appropriate supports were in place*";

p. *18 April 2017*: BRH reported serious concerns for Child ML, including the fact that vomiting episodes associated with electrolyte derangements (which occurred when Child ML was at home) did not occur when she was in hospital;

q. *21 April 2017*: Child ML was taken to Princess Margaret Hospital (PMH) for review. In a letter, Dr Ley outlined her concerns about Child ML's high sodium levels and stated that Child ML "*wouldn't have lived many days in this state had she not been brought to hospital*";[36]

r. *28 April 2017*: a serious injury-planning meeting was held at PMH to discuss concerns about Child ML's care. The meeting concluded that Child ML was "*at immediate risk of future harm*", and Child ML was taken into care the same day;

s. *June 2017*: a signs of safety meeting was held and it was determined that Ms B, an education assistant at Child ML's school, would be assessed as a "*significant other carer*";

[35] Exhibit 1, Tab 16.1, Report - Ms J McDonald (27.02.19), p2
[36] Exhibit 1, Tab 27, Attachment 2, Letter - Dr B Ley to PMH (23.04.17), p2

t. *1 July 2017:* on 1 July 2017, Child ML was transferred from PMH to BRH, to Lady Lawley Cottage on 3 August 2017;

u. *August 2017:* the Department requested Ms A to attend for urinalysis on 15 occasions, but she declined to do so; and

v. *23 August 2017:* the Department met with Ms A and advised her that she had been assessed as having caused "*significant harm*" to Child ML following the substantiation of medical neglect concerns.

Ms A said she accepted "*partial responsibility*" for harm caused to Child ML, which Ms A said had been due to her (Ms A's) mental health issues and exhaustion. Ms A also acknowledged "*using drugs*".

19. After Child ML's death, Ms Joanne McDonald (Child ML's caseworker) prepared a report in which she identified the following consistent concerns in relation to Ms A's care of Child ML:

(Ms A's) transience;

(Ms A's) choice of partners;

Drug Use – Methylamphetamine;

Neglect of (Child ML) and her siblings;

Child ML's non-attendance at school;

Consistent cancelling of medical appointments;

Scripts being sought before they were due to be filled;

(Child ML) not fed or bathed properly and her PEG site not kept clean

Not using the aids required by (Child ML) so that she is comfortable; and

(Ms A's) reluctance to take Child ML to hospital for medical intervention.[37]

[37] Exhibit 1, Tab 16.1, Report - Ms J McDonald (27.02.19), pp1-2

Child ML is taken into care[38,39,40,41]

20. The catalyst for the Department eventually taking Child ML into care on 28 April 2017, were her presentations to BRH in early 2017. On 21 February 2017, Child ML was admitted to BRH and diagnosed with very severe malnutrition and dehydration. Child ML had lost approximately 24% of her body weight, most likely as a result of not being properly fed by Ms A.[42]

21. On admission, Child ML was found to be unresponsive, lethargic and cold, and she had a very slow pulse rate. At the inquest, Dr Ley said clinical staff at BRH feared that Child ML might die within the first few days of her admission. However, over the next six weeks, Child ML regained the weight she had lost.[43]

22. Ms McDonald says that a multidisciplinary meeting was held and it was agreed to report Child ML's admission to the Department. However, despite the fact that "*Everyone was concerned that (Child ML) would not live for many more days if she was left with (Ms A)*", the Department concluded that "*it was safe for (Ms A) to take (Child ML) home with adequate supports and a safety net in place*".[44]

23. So it was that Child ML was discharged back into Ms A's care on 5 April 2017. Prior to Child ML's discharge, a safety plan was prepared which required Child ML to attend school daily, have weekly check-ups at BRH, and for Ms A to submit to urinalysis to monitor her illicit drug use.

24. Despite the safety plan, staff at BRH remained very concerned for Child ML's welfare, and as Dr Ley put it at the inquest, BRH staff "*felt that possibly the admission in February had been a cry for more help*".[45]

[38] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19)
[39] ts 26.09.23 (Ms A), pp13-16
[40] Exhibit 1, Tab 9, Statement - Ms A (30.05.19)
[41] Exhibit 1, Tab 12, Statement - Ms B (29.03.19), paras 2-8 and ts 27.09.23 (Ms B), pp139-144
[42] Exhibit 1, Tab 27, Report - Dr B Ley, Bunbury Hospital (14.09.23), pp2-4
[43] ts 26.09.23 (Dr Ley), pp86-87
[44] Exhibit 1, Tab 16.1, Report - Ms J McDonald (27.02.19), p2
[45] ts 26.09.23 (Dr Ley), p89

25. The concerns of clinical staff at BRH proved to be well founded, because at about 8.00 am on 7 April 2017, Ms A contacted BRH to advise that Child ML "*had a large vomit overnight and some diarrhoea*". Although Ms A was advised to bring Child ML to BRH, she did not immediately do so.[46]

26. At about 12.00 pm, Ms A advised BRH that Child ML had tolerated "*a little bit of water*", so she had decided not to bring her in. Ms A was again strongly advised to bring Child ML to BRH, and she eventually did so, but only after a caseworker told her that if Child ML was not brought to BRH by 5.30 pm, Crisis Care would be contacted.[47]

27. Thus, Child ML was returned to BRH (less than 40 hours after her discharge) and diagnosed with very high levels of sodium in her blood (hypernatremia), a very dangerous and potentially fatal medical condition. At the inquest, Dr Ley agreed that although the cause for Child ML's hypernatremia was never established, one possible cause was that something was being added to Child ML's feeding bags.[48]

28. Following this second admission, Child ML was taken into provisional care and protection on 28 April 2017. A protection order (time limited) for a period of two years was granted on 2 May 2017, and further protection orders (for periods of 12 months) were granted on 2 February 2018 and 2 January 2019 respectively.[49,50]

29. On 13 August 2018, the Department determined that Ms A had not met the requirements for reunification with (Child ML), and an application for a protection order (until 18 years) was made on 1 February 2019. Ms McDonald says that although Ms A was upset by the application, she (Ms A) agreed that she was not ready to care for Child ML on a full-time basis, and had raised the possibility of a "*shared care scenario*" for Child ML between herself and Ms B.[51,52,53,54]

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[46] Exhibit 1, Tab 16.1, Report - Ms J McDonald (27.02.19), p2
[47] Exhibit 1, Tab 16.1, Report - Ms J McDonald (27.02.19), p2
[48] Exhibit 1, Tab 27, Report - Dr B Ley, Bunbury Hospital (14.09.23), p5 and ts 26.09.23 (Ley), pp89-90
[49] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), paras 13, 21 & 38 and ts 27.09.23 (Hall), pp204-207
[50] Exhibit 1, Tab 31 Statement - Ms J McDonald (21.09.23), para 12
[51] Exhibit 1, Tab 16.1, Report - Ms J McDonald (27.02.19), p3
[52] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), paras 32-33 & 42 and ts 27.09.23 (Hall), pp204-207
[53] Exhibit 1, Tab 28-A1, Written Proposal for Child (01.02.19)
[54] Exhibit 1, Tab 31 Statement - Ms J McDonald (21.09.23), paras 45-47 and ts 26.09.23 (McDonald), pp178-179

30. Although the Department had determined that reunification was not possible in the foreseeable future, it remained an option, notwithstanding the fact that a protection order (until 18 years) had been applied for. The Department's decision to apply for that order was clearly correct and by the time it had determined that reunification was not feasible, the Department's concerns about Ms A's care of Child ML included:

- (Child ML) will not be fed the correct amount of formula over a 24-hour period, 7 days per week as prescribed by her dietician at PCH;

- (Child ML's) PEJ and PEG tubes will not be kept connected around the clock;

- (Child ML) will not receive the correct dosage of her medications as prescribed by her neurologist at PCH. (Ms A) may be taking (Child ML's clonazepam herself;

- (Child ML) will miss medical appointments that are compulsory for her health and well-being, due to (Ms A's) tardiness, lack of organisation, and forgetfulness;

- (Child ML's) bile bag will not be attached over a 24-hour period, 7 days per week, as required leading to (Child ML) becoming ill and at high risk of pneumonia. If this occurs, (Child ML) is likely to die;

- (Child ML) will arrive late to school most days or will not be taken; and

- When (Child ML) has extended stays in hospital she becomes quite unresponsive due to the lack of stimulation. (Child ML's) interaction with people is lessened and she appears to be 'robotic' in her interactions. If (Child ML) is returned to (Ms A's) care, there is a risk that (Child ML) will not be kept stimulated to the extent she is now at school and in the carer's home and will regress to an unresponsive state.[55]

[55] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19), p13

Placement in care[56,57,58,59]

31. At the time Child ML was taken into care by the Department, she was an inpatient at PMH. Child ML remained at PMH until 1 July 2017, at which time she was transferred to BRH. On 23 August 2017, Child ML was transferred to Lady Lawley Cottage, where she remained until she was placed into foster care.

32. After apprehending Child ML, the Department began the search for a suitable foster carer. Although the Department located a foster family for Child ML, Ms A objected because the family lived in Joondalup and she would have difficulties visiting Child ML.[60] Following a signs of safety meeting in June 2017, Ms A identified Ms B as a possible carer for Child ML.

33. Ms B was a special needs education assistant at the school Child ML attended, and had provided care to Child ML when she attended the school.[61] Following an assessment, the Department approved Ms B as Child ML's carer on 24 July 2017, and Child ML was placed into Ms B's care on 25 August 2017.[62]

34. After being approved as Child ML's carer, Ms B attended a three hour training session at Lady Lawley Cottage arranged by the Department. The session, which ostensibly dealt with Child ML's complex care needs including her medication and feeding regimes, was the only formal education Ms B ever received

35. In my view, given Child ML's highly complex care needs, the training provided to Ms B was woefully inadequate. However, by happy circumstance, because Ms B had been a special needs education assistant for many years, she was already familiar with the care needs of wheelchair bound children like Child ML.

[56] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19), pp1 & 11-13
[57] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), paras 11-46 and ts 27.09.23 (Hall), pp203-216
[58] Exhibit 1, Tab 31.1-31.6, Signs of Safety Assessment and Case Planning Forms (20.02.18-08.08.18)
[59] ts 26.09.23 (Ms B), pp140-142
[60] ts 27.09.23 (McDonald), pp186-187
[61] See also : Exhibit 1, Tab 21, Student Health Care Management & Emergency Response Plan
[62] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), para 18

36. Thus despite the paucity of her formal training, Ms B was able to manage Child ML's complex needs in a skilled and caring manner.[63] However, the stark reality of the responsibility she had assumed was clearly on Ms B's mind when Child ML was left in her care on 25 August 2017. At the inquest, Ms B made this comment:

> It…did feel funny, like when I got dropped off with (Child ML) and it was just, like, there you go. It's just you and me (Child ML)…But luckily I just knew what to do and what I was doing. My sister came and lived with me for a while, so she - we sort of did it together, just, yes, we just knew.[64]

37. The Department's initial plan was that Child ML would eventually be reunited with her mother Ms A. This goal is consistent with the Department's general approach, and this approach is pursued for children taken into care wherever possible. To facilitate the plan, Child ML had regular supervised contact visits with Ms A.

38. Initially, Ms B was required to supervise these visits because the Department did not have sufficient family resource workers to do so instead.[65] However, as she explained at the inquest, Ms B felt uncomfortable in the supervisory role.[66]

39. In my view, given Ms A's history of methylamphetamine use, and associations with persons alleged to be dealing in illicit drugs, it was clearly inappropriate to add supervision of contact visits to Ms B's already onerous list of responsibilities in relation to Child ML's care.

40. After Ms B had raised her concerns about supervising contact visits between Child ML and Ms A, the Department assumed this responsibility, before contact visits were eventually supervised by Mr and Mrs C, who were Child ML's "*safety network*".[67,68] As none of Ms A's family members lived in the Bunbury area, there was a need to identify suitable persons to be part of Child ML's "*safety network*".[69]

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[63] ts 26.09.23 (Ley), p90
[64] ts 27.09.23 (Ms B), p142
[65] ts 27.09.23 (McDonald), pp173-175 and see also: ts 28.09.23 (Mooney), p256
[66] ts 27.09.23 (Ms B), pp144-147 &165 and see also: ts 27.09.23 (McDonald), pp173-176
[67] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19), p6
[68] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), para 19
[69] Exhibit 1, Tab 31 Statement - Ms J McDonald (21.09.23), paras 23-24 and ts 26.09.23 (McDonald), pp188-189

41. However, Ms A was only able to identify Mr C and Mrs C, a married couple with whom she had been friends for some years. Mr and Mrs C offered a stable home environment, were in stable employment, and neither used illicit drugs.[70]

42. The Department's plan specified that the contact between Child ML and Ms A would only transition to being unsupervised when the Department had "*assessed it was safe and in (Child ML's) best interests*". This was a very sensible prerequisite to impose, given the context in which Child ML had been taken into care in the first place.[71]

43. After Child ML went into care, Ms A had supervised contact visits with her on Wednesdays from 12.00 pm to 5.00 pm, and Saturdays from 9.00 am to 5.00 pm. These visits moved to partial supervision in May 2018, and became unsupervised in July 2018. Further, in August 2018, Ms A began having overnight contact visits with Child ML, and initially, these visits were supervised by Mr and Mrs C.[72]

44. Ms A's overnight contact visits with Child ML became unsupervised on 29 October 2018, and by then were occurring in Ms A's own home. Although Ms McDonald had authorised unsupervised contact visits, this arrangement was promptly terminated in December 2018, when Ms McDonald's supervisor (Ms Hellen Hall) returned from leave and realised what was occurring. Thereafter, Ms A's overnight contact visits with Child ML returned to being supervised, and once again occurred at Mr and Mrs C's home.[73]

45. On the face of it, it is understandable that Ms McDonald should wish to promote reunification between Child ML and Ms A, and clearly unsupervised contact visits were one of the steps in that process. However, given Child ML's complex care needs and Ms A's limited personal and social resources at the relevant time, it was quite appropriate that Ms A should only be permitted to have supervised access to Child ML.

[70] ts 27.09.23 (McDonald), pp173 & 187-188
[71] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19), pp12-13
[72] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), para 30
[73] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), para 36 and ts 27.09.23 (Hall), pp206-208

46. Mr and Mrs C are to be highly commended for agreeing to be members of Child ML's safety network. However, the Department's assessment of their suitability to act in this role was rudimentary at best. Mrs C said she and her husband's role was to: "*help (Ms A) with (Child ML's) care and assist in monitoring her health*".[74] However, Mr and Mrs C were not interviewed by the Department about their suitability to be members of Child ML's safety network, and neither completed any application forms or other paperwork.

47. Further, although Mr and Mrs C were ostensibly required to "*supervise*" Ms A's care of Child ML during contact visits at their home, neither Mr C nor Mrs C had any proper understanding of what that entailed. That is because neither Mr C nor Mrs C had been given any training by the Department (or anyone else) about Child ML's complex medical conditions and care needs, including her feeding and medication regimes. Further, neither Mr C nor Mrs C were required to have current first aid certificates.[75]

48. In her statement to police, Mrs C said that Ms A was responsible for Child ML's "*feeding and administering medications*" and that:

> (Mr C) and I were happy to help (Ms A) with (Child ML) and be their supports, but we made it clear we weren't medically trained and had no involvement in that part of (Child ML's) care.[76]

49. Mr and Mrs C both said they attended periodic meetings with Ms McDonald at which they were expected to comment on the quality of care Ms A was providing to Child ML during contact visits. However, as Ms A was also present at these meetings, and as neither Mr C nor Mrs C had been given any training or information about Child ML's care needs, quite how they were expected to provide sensible feedback about the care provided to Child ML by Ms A is unclear.[77,78]

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[74] Exhibit 1, Tab 11, Statement - Mrs C (25.05.23), para 17
[75] ts 26.09.23 (Mr C), pp41-43; ts 26.09.23 (Mrs C), pp58-61 and ts 27.09.23 (McDonald), pp175-176
[76] Exhibit 1, Tab 11, Statement - Mrs C (25.05.23), paras 20-21
[77] ts 26.09.23 (Mr C), pp43-44
[78] See also: ts 27.09.23 (McDonald), pp177-179 and ts 27.09.23 (Hall), pp212-213

50. At the inquest, Mr C and Mrs C both referred to one occasion when Ms A had to be prompted to attend to Child ML who had been crying for an extended period, whilst Ms A was apparently asleep. However, Mr C said over time, Ms A's care of Child ML improved and that he and his wife had been:

> [B]rought in to…curb her behaviour and get her off her phone and pay more attention…and that was part of our jobs as support people it was explained to us".[79]

51. Mr C agreed that in the absence of any training or information about Child ML's medical conditions and/or care needs, he was "*essentially an uninformed bystander*" during contact visits. At the inquest, Mr C was also asked whether it would have been beneficial for him to have received "*some information or education*" about Child ML's care needs, and his enthusiastic response was "*Absolutely. Absolutely*".[80]

52. Despite the lack of clarity about exactly what was expected from them, from a practical point of view, it seems that as members of Child ML's safety network, Mr and Mrs C were able to: provide a stable home of suitable size; ensure that Ms A was physically present so she could care for Child ML; and ensure that Ms A was not using methylamphetamine (or other illicit substances) whilst she was caring for Child ML.

Issues in Child ML's care[81,82,83,84]

53. In my view, the available evidence establishes the following inadequacies in the Department's management of Child ML's care:

a. *Missed opportunities to provide more support:* given the numerous welfare concerns that had been raised during the period 2013 - 2016, there were missed opportunities where the Department could (and should) have provided support to Ms A as she cared for Child ML;

[79] ts 26.09.23 (Mr C), p44 and ts 26.09.23 (Mrs C), pp62-63
[80] ts 26.09.23 (Mr C), p45
[81] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19)
[82] Exhibit 1, Tab 15.2, Report - Mr B Mooney (18.09.23)
[83] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23)
[84] ts 26.09.23 (Ms A), pp17-24

b. *Apprehension of Child ML:* the Department should have taken Child ML into care following her presentation to BRH on 21 February 2017, in circumstances where she was a matter of days away from death. Further, the safety plan implemented prior to Child ML's discharge back into Ms A's care on 5 April 2017, was insufficiently rigorous and did not properly address the concerns raised by BRH staff.

   At the inquest Mr Brendan Mooney (the Department's Regional Executive Director, South West) agreed that Child ML should have been taken into care following her admission to BRH on 21 February 2017, rather than being discharged into Ms A's care. Mr Mooney also accepted that the level of support the Department provided to Ms A (even under Child ML's discharge safety plan) could have been improved;[85]

c. *Support to Ms B*: the Department should have provided additional support to Ms B during Child ML's placement with her. I note that during no Carer Support plan was drafted, there were no ongoing assessments of whether Ms B was maintaining her care competencies, and there were no ongoing assessments of whether Ms B required additional support, including respite care;[86]

d. *Reunification plan*: whilst the goal of reunification between Ms A and Child ML is understandable, Child ML's reunification plan did not properly consider whether Ms A was able to competently manage Child ML's full-time care. Further, despite ongoing issues with Ms A's methylamphetamine use, and her capacity to manage Child ML's complex needs, no comprehensive safety plan was developed to mitigate these concerns. Nevertheless, in my view, the Department's ultimate conclusion that reunification between Child ML and Ms A was inappropriate and its decision to seek a protection order (until 18 years), was clearly correct;[87]

e. *Training provided to Ms B*: in view of Child ML's complex care needs, the training provided to Ms B prior to her assuming Child ML's full-time care was inadequate and further, Ms B was not required to have a current first aid certificate.

[85] ts 28.09.23 (Mooney), pp262-263
[86] ts 27.09.23 (Ms B), p163
[87] ts 27.09.23 (Hall), pp208-210

At the inquest, Mr Mooney conceded that in relation to the training provided to Ms B, "*more could have been done*", and that any information provided should have been documented;[88,89]

f. *Assessment of safety network members*: the process to determine whether Mr C and Mrs C were suitable members of Child ML's Safety Network was clearly inadequate. Further, as I have explained, the role that Mr and Mrs C were expected to perform in relation to Ms A's care of Child ML was poorly formulated and their ability to offer meaningful support to Ms A during contact visits with Child ML was limited; and

g. *Training provided to Mr C and Mrs C*: neither Mr or Mrs C received any education or training about Child ML's medical conditions, or her complex care needs including her feeding and medication regimes, and neither were required to have current first aid certificates. In my view, this severely limited the capacity of Mr C and Mrs C to properly support Ms A in her care of Child ML, and also compromised their ability to recognise and respond to any deterioration in Child ML's medical condition.

Comments on Ms B's care of Child ML[90]

54. The evidence establishes that Ms B attended to Child ML's needs in a diligent, skilled, and caring manner. During this time, Child ML gained weight and attended school regularly. Further, because Ms B ensured Child ML's medications were given correctly, and her feeding tubes were kept clean and hygienic, there were fewer hospital admissions.[91]

55. Ms B also ensured that Child ML attended numerous appointments with her care team, including her paediatrician, dietician, occupational therapist, physiotherapist, respiratory physician, and gastroenterologist. At the inquest, Dr Ley said Ms B: "*gave (Child ML) very lovely care. She gained weight. She was happy. She was attending school. She was doing well*".[92]

[88] ts 27.09.23 (Ms B), p162
[89] ts 28.09.23 (Mooney), pp255-256
[90] Exhibit 1, Tab 31 Statement - Ms J McDonald (21.09.23), paras 25-39
[91] See also: ts 27.09.23 (McDonald), pp189-190
[92] ts 26.09.23 (Ley), p90

56. For its part, the Department made the following observations about Ms B's care of Child ML:

> Whilst in the care of (Ms B), (Child ML) gained 9 kgs in weight, had her medication delivered to her via her PEJ at the correct times and dosages through being kept on a continual feeding system, and had her bile bag attached to the PEJ which reduced reflux and the risk of aspiration leading to aspirated pneumonia. (Ms B) ensured (Child ML) attended all her medical appointments and school daily.[93]

57. In her statement to the Court, Ms Hall stated that:

> (Ms B) provided exceptional care of Child ML, which is evidenced by Child ML's increase in health and capacity over her time in (Ms B's) care.[94]

58. Given that Child ML was non-verbal, her views about her placement in Ms B's care could not be obtained orally. Nevertheless, Child ML's caseworkers noted that she "*smiled and made cooing sound when in (Ms B's) care demonstrating she was attached to (Ms B) and her family*".[95]

59. It takes a lot to agree to foster a child with routine needs. However, as a result of her medical conditions, Child ML required a very high level of care and attention. Taking on Child ML's care must have been a daunting prospect, and Ms B is to be highly commended for her willingness to shoulder this onerous responsibility.

60. Having considered the available evidence, I find that Ms B provided Child ML with an excellent standard of care during the time Ms B was her foster carer.

[93] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19), p15
[94] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), para 46
[95] Exhibit 1, Tab 15.1, Report - Ms R Green (26.08.19), pp10-11

EVENTS LEADING TO CHILD ML's DEATH[96,97,98,99]

61. I now turn to the events which led up to Child ML's death. During the weekend of 23-24 February 2019, Child ML had a supervised access visit with Ms A. According to Ms A, when Child ML was collected from Ms B's house on 23 February 2019, Ms B told Mrs C that Child ML had "*a bit of a fever*", "*had been sick for about 3-4 days*", and had "*been bringing up clear frothy mucus in her saliva*".[100]

62. Ms B says that on 22 February 2019, Child ML had "*a bad sleep due to her experiencing reflux and* (was) *coughing quite a lot*". Ms B noted that Child ML was due to have a new PEJ tube inserted, and that in the meantime, the recommended treatment was "*to administer an additional dose of medication each day, with the infection and coughing usually clearing after about a week*".[101]

63. Ms B said that on the morning of 23 February 2019, Child ML was "*still coughing a fair bit*", but that as Child ML's symptoms were being treated with additional medication, Ms B "*had no concern to stop the supervised visit with* (Ms A)". Ms B also says she told Mrs C about Child ML's coughing and the additional medication Child ML was being given, and Ms B noted that these matters were also recorded in the "*communication book*" which Ms A was given each time she had contact visits with Child ML.[102]

64. In her statement to police, Mrs C says that she picked up Child ML from Ms B's home in the morning, and that:

> On handover, (Ms B) told me (Child ML) wasn't feeling well and had a higher temperature than usual. (Ms B) wasn't overly concerned and said that otherwise, (Child ML) seemed fine.[103]

[96] Exhibit 1, Tab 8.1, Report - Coronial Investigation Squad, pp3-4
[97] ts 26.09.23 (Ms A), pp23-29; ts 26.09.23 (Mr C), pp48-49 and ts 26.09.23 (Mrs C), pp64-77
[98] Exhibit 1, Tab 10, Statement - Mr C (30.05.19), paras 21-49
[99] Exhibit 1, Tab 11, Statement - Mrs C (25.05.23), paras 24-65
[100] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), paras 13-14
[101] Exhibit 1, Tab 12, Statement - Ms B (29.03.19), paras 30-33 and ts 27.09.23 (Ms B), pp154-157
[102] Exhibit 1, Tab 12, Statement - Ms B (29.03.19), paras 35-36
[103] Exhibit 1, Tab 11, Statement - Mrs C (25.05.23), paras 25-26

65. Ms B noted that apart from Child ML's coughing, Child ML was "*happy in herself, presenting fine and with no lethargy*". On the day of Child ML's death, Ms B says Ms A told her that Child ML had completely stopped coughing. Ms B says this "*seemed odd*" because it normally took Child ML a week "*to settle*".[104]

66. In any case, at the inquest, Ms A said that when she saw Child ML on 23 February 2019, Child ML's temperature was initially "*fine*", but she was "*quite gurgly*". In her statement Ms A also says when she checked Child ML's temperature at about 6.30 pm, it was 38.2℃.[105]

67. Ms A says she told Mrs C that if she couldn't get Child ML's temperature down "*within an hour*", she would take Child ML to hospital. Ms A says she noted that Child ML was "*bringing up some frothy bile*", and after giving her some Panadol (paracetamol) and Nurofen (ibuprofen) she (Ms A) lay with Child ML in a hammock outside where a cool breeze was blowing.[106,107]

68. Ms A says she and Child ML fell asleep, and that when she woke up she re-checked Child ML's temperature and it was 36.4℃. Child ML was no longer coughing up mucus, and Ms A was happy that as her temperature had come down, Ms A did not need to take Child ML to hospital.[108]

69. Ms A and Child ML went to bed sometime between 9.00 pm and 9.30 pm. Child ML was lying on her stomach, and Ms A says she used pillows "*to elevate* (Child ML) *and build her up on an angle*". This meant that Child ML was "*basically on her tummy/side with her head to one side*", so that "*if she was asleep and brought up anything, it would dribble to the side and she wouldn't choke on anything*".[109,110]

[104] Exhibit 1, Tab 12, Statement - Ms B (29.03.19), paras 38-40 and ts 27.09.23 (Ms B), p166
[105] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), para 14 and ts 26.09.23 (Ms A), p24
[106] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), paras 16-17 and ts 26.09.23 (Ms A), p25
[107] See also: Exhibit 1, Tab 11, Statement - Mrs C (25.05.23), paras 30-35
[108] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), para 18 and ts 26.09.23 (Ms A), p25
[109] Exhibit 1, Tab 11, Statement - Mrs C (25.05.23), para 36
[110] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), paras 18-20 and ts 26.09.23 (Ms A), p25

70. Ms A says when she woke up at about 3.30 am on 24 February 2019, she noticed Child ML was "*happy and smiling*". Ms A says after she changed her nappy, Child ML went back to sleep. At this time, Child ML's feeding machine was off, which Ms A said was "*normal*", and when Child ML woke up at about 7.00 am, Ms A says she turned the feeding machine back on "*with some water and Hydrolytes*", before giving Child ML her morning medication.[111]

71. At the inquest, Ms A was asked whether she gave Child ML more Panadol and Nurofen with her morning medication and her response was "*I don't believe so. Honestly, I'm not sure. Sorry*".[112] This leaves open the possibility that Child ML was given Panadol on the morning of her death, which seems to be consistent with the toxicological findings I will discuss later in this finding.

72. In any case, Ms A says Child ML was not coughing when she woke up, and that after Child ML went back to sleep, Ms A could hear her snoring. Ms A said that although Child ML didn't always do this, she did snore "*when she is sick and* (it) *can be like heavy breathing*". Ms A says that Child ML was still asleep at 9.30 am, and she changed Child ML's position by moving her head.[113]

73. In her statement to police, Ms A says Child ML was breathing heavily and when she checked her temperature it was "*in the 36 degrees area*". Ms A says that "*as this was normal*", she did not give Child ML "*any more Panadol*". Ms A also noticed Child ML was "*bringing up green goop, thick saliva*" and she "*cleaned up her mouth"*.[114]

74. Ms A says that as she did this, she noticed Child ML's lips were "*still pink, not pale*". Ms A says she then left Child ML in bed asleep and went to the adjacent bathroom to clean her teeth and brush her hair. Ms A says that when she went back into the bedroom about 20 minutes later, Child ML was still in the same position, and when she checked on her, Ms A realised that Child ML was not breathing.[115]

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[111] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), para 21-23 and ts 26.09.23 (Ms A), pp25-26
[112] ts 26.09.23 (Ms A), p27
[113] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), paras 24-26
[114] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), paras 26-27
[115] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), paras 26-30 and ts 26.09.23 (Ms A), pp27-28

75. Ms A says she started performing CPR while Child ML was lying on the bed while she called out for Mrs C to ring for an ambulance. Ms A says that Mrs C came into the bedroom and placed Child ML on the floor before resuming CPR, while Mr C called emergency services.[116,117,118]

76. Ambulance officers arrived a short time later and took over resuscitation efforts. Ms A says that after about five minutes, the ambulance officers asked her if she wanted them to continue their resuscitation efforts. Ms A says she asked the officers if Child ML "*had gone*", and when the officers replied "*yes*", she told them to cease CPR, which they did.[119,120,121,122,123,124]

77. One of the attending ambulance officers declared Child ML deceased at 11.15 am, and police arrived a short time later and began an investigation into Child ML's death.[125,126,127]

[116] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), paras 31-34 and ts 26.09.23 (Ms A), pp28-29
[117] Exhibit 1, Tab 10, Statement - Mr C (30.05.19), paras 37-39
[118] Exhibit 1, Tab 11, Statement - Mrs C (25.05.23), paras 44-51
[119] Exhibit 1, Tab 9, Statement - Ms A (30.05.19), paras 35-39
[120] See also: Exhibit 1, Tab 10, Statement - Mr C (30.05.19), paras 40-49
[121] See also: Exhibit 1, Tab 11, Statement - Mrs C (25.05.23), paras 52-54
[122] Exhibit 1, Tab 13.1, SJA Patient Care Record - Crew EBU41DC (24.02.19)
[123] Exhibit 1, Tab 13.2, SJA Patient Care Record - Crew AUS21DC (24.02.19)
[124] Exhibit 1, Tab 13.3, SJA Ambulance Operations Call Card(24.02.19)
[125] Exhibit 1, Tab 3, Life Extinct Form (24.02.19)
[126] Exhibit 1, Tab 8.1, Report - Const. M Reid (01.06.19)
[127] See also: Exhibit 1, Tab 14, Department of Communities - Child Death Notification (25.02.19)

CAUSE AND MANNER OF DEATH

Post mortem examination[128,129,130,131]

78. A forensic pathologist (Dr Jodi White) conducted a post mortem examination of Child ML's body on 27 and 28 February 2019. Dr White noted Child ML had postural changes and muscle wasting, which were consistent with her history of cerebral palsy.

79. Although a feeding tube was present, as I will explain later in this finding, neither the tube (nor the feeding bags which had accompanied Child ML to the State Mortuary) were analysed.

80. Child ML's lungs were heavy and thickened, and she had congested airways with aspiration. Microscopic examination of tissues found features of chronic aspiration, and fluid and chronic inflammation within the supporting tissues of the lungs (interstitium), trachea and bronchi. There was also evidence of an evolving, acute pneumonia (infection of the lungs).

81. Virological testing detected *Rhinovirus* in Child ML's lung tissues and trachea, and microbiological testing found the bacterium *Klebsiella pneumoniae* in blood samples, and *Staphylococcus aureus* in lung tissue. Dr White said these bacteria were considered to be "*true pathogens*" rather than being present as a result of post mortem contamination.

82. Specialist examination of Child ML's brain confirmed Child ML's head was much smaller than expected (microencephaly), and there was a reduction in the amount of white matter, with widespread gyral abnormalities and dilation and thinning of the corpus callosum.

83. Dr White noted that severe neurological complications can occur with twin-to-twin transfusion syndrome, but that the disease process (pathogenesis) is poorly understood.

[128] Exhibit 1, Tab 4.1, Supplementary Post Mortem Report (03.06.22)
[129] Exhibit 1, Tab 4.2, Post Mortem Report (28.02.19)
[130] Exhibit 1, Tab 5, Neuropathology Report (29.04.19)
[131] ts 27.09.23 (White), pp191-195

Toxicological analysis[132,133,134,135,136]

84. Aspects of the results of Child ML's toxicological testing were considered to be of concern, and Dr White sought an expert opinion from Professor David Joyce, an experienced physician, pharmacologist and toxicologist. In his detailed report, Professor Joyce noted that the following substances had been detected in Child ML's system:

a. *Clonazepam*: although clonazepam (a benzodiazepine medication) was not detected in Child ML's blood, its main metabolite, 7-aminoclonazepam, was. Professor Joyce explained that the metabolite normally accumulates to "*concentrations exceeding the parent drug during chronic therapy*", explaining why it is sometimes detected without the parent drug in post mortem analysis;[137]

b. *Diazepam*: this benzodiazepine medication was detected at levels that would be explained by the regime Child ML was on in hospital in September 2018. In a report to the Court, Dr Ley (Child ML's paediatrician) confirmed that Child ML would have been prescribed diazepam at the time of her death.[138] Professor Joyce noted that oxazepam and temazepam, were also detected in Child ML's system, but as both medications are metabolites of diazepam, "*their presence in the analysis is well enough explained by the diazepam treatment*".[139]

In sufficient amounts all of these benzodiazepines can supress the drive to breath, but the concentrations found in Child ML's system would "*pose no risk to a healthy child*". However, Child ML had serious respiratory issues, and as I will explain later in this finding, she also had codeine in her system that has a synergistic effect with benzodiazepines, and can cause sedation and respiratory depression.[140]

[132] Exhibit 1, Tab 6.1, Supplementary Toxicology Report (01.10.22)
[133] Exhibit 1, Tab 6.2, Toxicology Report (29.10.19)
[134] Exhibit 1, Tab 6.3, Email - Dr J White (16.05.23)
[135] Exhibit 1, Tab 6.3, Email - Prof. D Joyce (15.05.23)
[136] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21) and ts 28.09.23 (Joyce), pp228-242
[137] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), pp7-8
[138] Exhibit 1, Tab 27, Report - Dr B Ley, Bunbury Hospital (14.09.23), p1
[139] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p8
[140] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p8

c. *Baclofen*: this medication helps manage the muscle rigidity and spasms that can occur with cerebral palsy. The concentration found in Child ML's system was somewhat higher than levels reported in adult patients taking the medication, but well below any concentration associated with a lethal outcome.[141]

d. *Gabapentin*: this medication also helps manage muscle rigidity and spasms that can occur with cerebral palsy. The concentration in Child ML's blood was "*unexpectedly high*" when compared to concentrations seen in adult patients, and "*within the range associated with overt intoxication, at least in adults*".[142]

Although this would cause drowsiness, Professor Joyce noted there was normally "*no suppression of the drive to breath during conventional therapy*" and even the relatively high concentration detected in Child ML's system "*should still be safe*".[143]

e. *Valproate*: this anti-epileptic medication was detected at therapeutic levels in Child ML's system and Professor Joyce concluded that "*No adverse effects would be expected at this concentration*".[144]

f. *Codeine*: is an opioid medication, whose metabolites include morphine. Professor Joyce said that the levels detected in Child ML's system confirm that she "*received an overdose of codeine*".[145] Further, although Child ML's levels of codeine would not have threatened the life of a healthy adult, Professor Joyce expressed the opinion that the detected levels represented:

> An appreciable risk to a child, even without other drugs or the underlying risk to ventilation that (Child ML) had.[146]

[141] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), pp8 & 13 and ts 28.09.23 (Joyce), p233
[142] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), pp9 & 13 and ts 28.09.23 (Joyce), pp233-234
[143] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p9
[144] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p9
[145] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), pp10-11 & 13 and ts 28.09.23 (Joyce), p229
[146] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p11

In his report, Professor Joyce said that the relative concentrations of codeine (and its metabolites) found in Child ML's system strongly suggested:

> That the codeine was mostly or entirely from a recent dosing, rather than from regular dosing.[147]

Professor Joyce noted that the "*conventional maximum codeine dose is 60 mg*", which is the amount contained in two tablets of the highest strength codeine formulations currently available in Australia.

Professor Joyce referred to a published study where adults weighing 70 kg took two 60 mg codeine tablets and were found to have a maximum plasma concentration 0.47 mg/L in plasma, which is approximately equivalent to 0.5 mg/L in whole blood. Professor Joyce noted that:

> (Child ML's) concentration exceeds this, at 0.83 mg/L, implying that her dose, on a weight adjusted basis, might have been comparable to or greater than the 120 mg in a healthy, 70 kg adult. Codeine is subject to post-mortem distribution…so dose estimation cannot be made any more precisely than this.[148]

Professor Joyce also observed that codeine is "*not that much used in children*", and also that it has:

> [S]carcely any credible indications in children, so it's virtually not used, and virtually all childhood exposure that comes to attention is through misadventure.[149]

g. *Paracetamol*: in his report, Professor Joyce stated that the levels of paracetamol found in Child ML's system pointed to "*recent ingestion*" of a dose that was "*high, for a child who has received an age-appropriate dose, but not high enough to threaten health or life*".[150]

[147] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), pp10-11 & 13
[148] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p10
[149] ts 28.09.23 (Joyce), p231
[150] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p12

At the inquest, Professor Joyce also noted that:

> The concentration (of paracetamol) found in blood was higher than one would normally expect…shortly after a dose in an appropriately dosed child. So, what was there would not be explained by an appropriate dose given the previous night.[151]

In his report, Professor Joyce explained that the commonest way to prescribe codeine was by way of medications containing both paracetamol and codeine, suggesting that:

> The codeine in this case has come from one of the common co-formulations, like Panadeine Forte, Codalgin Forte (and/or) Codapane Forte tablets.[152]

At the inquest, Professor Joyce agreed Child ML had likely been given paracetamol and codeine in tablet form, noting:

> That's where the high-dose formulations are to be found…the liquid formulations, there are some which have a little bit of codeine in them, but they would not have created a simultaneous excessive dosing with paracetamol and codeine.[153]

h. *Ibuprofen*: is an analgesic and anti-inflammatory medication, and the levels detected in Child ML's system had "*no toxicological significance*".[154]

i. *Omeprazole*: this medication is used to treat gastro-oesophageal reflux and other than noting the medication had been prescribed to Child ML, Professor Joyce made no comments about the levels detected.[155]

j. *Valpromide*: this medication is used to treat epilepsy and was found in Child ML's urine. Although its presence "*is not explained*", Professor Joyce said the levels detected had "*no toxicological significance*".[156]

[151] ts 28.09.23 (Joyce), pp229-230
[152] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p12 and see also: ts 28.09.23 (Joyce), pp229 & 238
[153] ts 28.09.23 (Joyce), p238
[154] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p11
[155] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p12
[156] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p12

Why the presence of codeine is significant[157]

85. In addition to the medications already mentioned, codeine is also found in the pain relief medications Nurofen Plus, and Mersyndol, and the cold and flu medications Codral, and Demazin, both of which also contain paracetamol.

86. However, since 1 February 2018, medications containing codeine have required a prescription,[158] and the available evidence is that at the time of her death, neither Child ML nor any of the adults in her immediate proximity (i.e.: Ms A and Mr and Mrs C), were being prescribed any medication containing codeine.[159,160]

87. In his report, Professor Joyce explained that codeine is an opioid medication, whilst clonazepam, diazepam, oxazepam, and temazepam are benzodiazepine medications. Persistent exposure to either or both opiate or benzodiazepine medications engenders tolerance, meaning the patient becomes more resistant to both the beneficial, and the harmful effects of the respective medication. At the inquest, Professor Joyce also referred to recent data that confirmed that patients taking gabapentin (as Child ML was) are more susceptible to opioid toxicity than had been previously understood.[161]

88. Professor Joyce also noted that in the case of opioid drugs, tolerance translates to requiring a greater dose of the medication to achieve the same beneficial effect, and that tolerance can develop quickly. However, because Child ML was not prescribed any opioid medication she "*would not be expected to have any tolerance to codeine or morphine*".[162,163] In any case, the protection (including protection from lethality through respiratory distress) afforded by tolerance was "*unreliable*", and Professor Joyce noted that a number of opioid and benzodiazepine-habituated patients died from their drug use.[164]

[157] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), pp12-14
[158] See: www.tga.gov.au/news/news/codeine-information-hub
[159] ts 26.09.23 (Ms A), p38; ts 26.09.23 (Mrs C), p69; and ts 26.09.23 (Ley), p96
[160] Exhibit 1, Tab 8.2, Memorandum - Det. Sgt. G Reed (11.05.23), p2
[161] ts 28.09.23 (Joyce), p239
[162] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p12
[163] See also: Exhibit 1, Tab 11, Statement - Mrs C (25.05.23), para 55
[164] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p12

89. Professor Joyce noted that there was "*very extensive experience*" in forensic toxicology concerning the lethality of a combination of opioid and benzodiazepine medications, and this effect is particularly relevant for patients (like Child ML) with chronic respiratory issues.[165]

90. Further, as Professor Joyce pointed out in his report, Child ML's respiratory issues were:

> [S]evere enough to require constant surveillance over her breathing efficiency, immediate access to oxygen and suction, and repeated hospital admissions. In March 2018, this reached the point of Type 1 respiratory failure.[166]

91. Professor Joyce noted that in the context of Child ML's compromised respiratory function, even "*small insults*" to her respiratory drive, ventilator muscle efficiency, or lung function "*could have been enough to bring her to terminal respiratory failure*". Further, Child ML's history of coughing in the days leading up to her death may have meant "*she was more compromised than usual when she received the codeine*".[167]

92. Professor Joyce also noted that evidence of aspiration was detected during Dr White's post mortem examination of Child ML's body, and that this is a common finding in opioid related deaths.[168]

93. As to the effects when opioid and benzodiazepine medications are consumed together (as in Child ML's case), Professor Joyce stated:

> Alone, opioid drugs are much more important respiratory depressants than benzodiazepine drugs. The similarity begets synergism, meaning that the combination of opioid and benzodiazepine depresses respiration more severely than either drug alone. A synergism with baclofen and gabapentin might be postulated, but can't be made more quantitative.[169]

[165] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), pp12-13
[166] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p13
[167] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p13 and ts 28.09.23 (Joyce), p234
[168] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p13 and ts 28.09.23 (Joyce), p234
[169] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p13

94. Professor Joyce noted that sedating drugs (and opioids in particular), carry "*a very high risk of tipping the precariously balanced patient into terminal respiratory failure*". Opioids can also cause sedation, direct suppression of the drive to breath, and vomiting leading to aspiration and these effects interact.[170]

95. As to the potential consequences of the levels of codeine and morphine found in Child ML's system, in his report, Professor Joyce expressed the following conclusions:

> The overall evidence therefore strongly implicates the codeine and morphine as contributors to the cause of death. It does not exclude the possibility that a second acute pathology, respiratory tract infection, was also in evolution.[171]

96. At the inquest, Professor Joyce confirmed his view that Child ML's high levels of codeine and morphine were strongly implicated as contributors to her death, but also said:

> I would just observe as a general physician that this kind of history of recurrently getting almost to the brink of dying from respiratory illness will, eventually, in one episode, get to the point of dying from a respiratory illness there. So (Child ML) may well have been destined to die from the respiratory illness even without the opioid exposure.[172]

97. Regardless of the precise mechanism of Child ML's death, given the fact that codeine (and its metabolite morphine) are strongly implicated as contributors to her death, the obvious question that arises is: "*How did Child ML Come to have such high levels of codeine and morphine in her system?*" This question is especially pertinent because of the fact that at the time of her death Child ML was not being prescribed codeine. Further, because Child ML was confined to a wheelchair and could take nothing by mouth, she could not have given herself any substance, much less a medication containing codeine.

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[170] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p13 and ts 28.09.23 (Joyce), pp235-239
[171] Exhibit 1, Tab 7, Report - Prof. D Joyce (30.04.21), p14
[172] ts 28.09.23 (Joyce), pp241-242

98. At all relevant times during Child ML's period of overnight weekend access, she was supposedly under the direct care of Ms A, who in turn was ostensibly being "*supervised*" by Mr C and Mrs C.

99. At the inquest, Ms A agreed that during the weekend contact visit, she was solely responsible for feeding Child ML and giving her medication. However, although Ms A admitted having given Child ML both Panadol (paracetamol), and Nurofen (ibuprofen) in addition to her prescribed medication, she flatly denied giving Child ML any substance containing codeine, even inadvertently.[173]

100. Ms A also denied she was concerned about getting into trouble because Child ML had been found with such high levels of codeine in her system, saying: "*Well no, because I never gave her anything, so I have got nothing to hide*".[174]

101. At the inquest, the following exchange took place between Counsel Assisting (Ms Markham) and Ms A:

> *Ms Markham:* So as far as you are concerned, it's a mystery as to how the codeine got into Child ML's system?
>
> *Ms A:* I know it sounds stupid, but yes. I never gave it to her.[175]

102. When I asked Ms A whether there was anything she could tell the Court about how it was possible for Child ML to have been found with such high levels of codeine in her system, Ms A replied: "*No, I can't answer that. I am sorry. I don't know*".[176]

103. For their part, both Mr C and Mrs C denied giving Child ML any medication at all, and each of Ms A, Mr C, and Mrs C also denied that anyone other than themselves had access to Child ML during the weekend.[177]

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[173] ts 26.09.23 (Ms A), pp25-26 & 29-38
[174] ts 26.09.23 (Ms A), p38
[175] ts 26.09.23 (Ms A), p35
[176] ts 26.09.23 (Ms A), p38
[177] ts 26.09.23 (Ms A), pp35; ts 26.09.23 (Mrs C), pp71-73; and ts 26.09.23 (Mr C), p45

104. Following her death Child ML's feeding bags and tubes and syringes were photographed by police. The feeding bags and tubes (which had been connected to Child ML's body) accompanied Child ML to the State Mortuary, but these items were not formally seized and the Officers did not make any request that these items be analysed.[178,179]

105. The information from Ms A had been that Child ML's life expectancy was only three to five years, and she was seven years of age at the time of her death. In that context, by the time Child ML was received at the State Mortuary, her death was being treated as "*non-suspicious*".[180]

106. However, notwithstanding the fact that the results of toxicological analysis of samples taken from Child ML's body had not yet been received, Child ML's feeding bags and tubes were disposed of without being analysed.

107. Clearly the disposal of Child ML's feeding bags and tubes before they were analysed is very unfortunate, and means there is now no way of confirming exactly how the codeine found in Child ML's system was administered.

108. Although Child ML's stomach contents were analysed, only small amounts of codeine, morphine and gabapentin were detected, which was not consistent with an overdose by mouth.[181,182]

109. In any case, given Child ML's "*unsafe swallow*"[183] it seems most likely that the codeine found in her system was administered via a syringe into an extension to her PEJ tube, after codeine/paracetamol tablets had been dissolved in liquid.

110. Whilst It is also possible that codeine was administered to Child ML via a feeding bag, but as this was not how she generally received her medication, this seems less likely.

[178] ts 27.09.23 (Haworth), pp132-135
[179] Exhibit 1, Tab 8.3, Running Sheet: Incident Report 240219 1130 15766
[180] See for example: Exhibit 1, Tab 24, Incident Report 240219 1130 15766
[181] Exhibit 1, Tab 6.1, Supplementary Toxicology Report (01.10.22)
[182] Exhibit 1, Tab 6.3, Email - Prof. D Joyce to Mr W Stops (15.05.23)
[183] Exhibit 1, Tab 19, Report - Dr B Ley, Bunbury Hospital (05.03.19)

111. Whatever the actual method of administration of codeine to Child ML may have been, on the basis of the available information (and in particular the evidence of Professor Joyce), it seems highly likely that Child ML was given a medication containing both codeine and paracetamol (in tablet form that was then dissolved in liquid) in the hours before her death.

112. In deciding whether I can make a definitive finding about how Child ML came to have a large quantity of codeine in her system, I must have regard to the principle set out by the High Court in a decision known as *Briginshaw v Briginshaw*.[184] In that case, it was determined that a consideration of the nature and gravity of the conduct was required when deciding whether a finding adverse in nature has been proven on the balance of probabilities (the Briginshaw principle).

113. After applying the Briginshaw principle to the present case, I have concluded that the available evidence does not allow me to make any findings as to: who gave Child ML codeine and paracetamol; how this substance was administered; and/or why this was done.

114. It may very well be that whoever gave Child ML a medication containing codeine and paracetamol, did so in an effort to alleviate her coughing and respiratory symptoms, without realising the potentially fatal consequences of their actions. Nevertheless, the fact that Child ML must have been given a large dose of codeine by someone, means that the standard of supervision and care she received from Ms A in the period leading up to her death was demonstrably and woefully substandard.

115. Further, as I have pointed out, neither Mr C nor Mrs C received any education or information about Child ML's medical conditions, or her medication and/or feeding regimes. As a consequence, neither Mrs C nor Mr C were in a position to provide Ms A with the level of supervision and/or support that Ms A clearly required.

[184] (1938) 60 CLR 336 at 361-362 per Dixon J

Cause and manner of death

116. At the conclusion of her post mortem examination, Dr White expressed the following opinion about the cause of Child ML's death:

> Pneumonia complicating a viral respiratory illness with acute combined drug effect in a young girl with cerebral palsy, recurrent aspiration, and chronic seizure disorder.[185]

117. At the inquest, Dr White confirmed that the words "*acute combined dug effect*" in her conclusion about the cause of Child ML's death, were a reference to all of the medications found in Child ML's system, including codeine, morphine, and gabapentin.[186]

118. I respectfully accept and adopt Dr White's opinion as to the cause of Child ML's death.

119. For the reasons I have explained, I have been unable to determine how and/or why Child ML was given large amounts of codeine and paracetamol in the period before her death.

120. Further, after carefully examining the available evidence, I have been unable to determine whether Child ML's death occurred by way of homicide, accident or natural causes and therefore, I make an open finding as to the manner of her death.

[185] Exhibit 1, Tab 4.1, Supplementary Post Mortem Report (03.06.22)
[186] ts 27.09.23 (White), pp200-201

POLICE INVESTIGATIONS

Initial investigation[187,188,189,190,191]

121. At about 11.30 am on 24 February 2019, Constable Michelle Reid (Officer Reid) and Ms Joanne Haworth (Ms Haworth) who at the time was an Acting Sergeant, but who has since retired as a police officer, arrived at an address in Australind in relation to a Computer Aided Dispatch (CAD) job, relating to Child ML's death.

122. Officer Reid and Ms Haworth (the Officers) were provided with information about the task they were attending by way of an incident report relating to the CAD job. The incident report contains an entry at 11.23 am (i.e.: prior to the Officers arriving at the scene) which describes the task they were attending in these terms:

> SJA are on scene. 7 yr old female deceased. Expected death as child was terminal".[192]

123. In my view, the significance of the task being described in this way cannot be overstated. I will have more to say about this issue shortly, but for now I note that neither of the Officers had previously attended a child death.

124. Officer Reid, who had been a police officer for about four years at the relevant time, had attended fatal incidents. However, none of these incidents involved criminality, and instead related to suicides and a drug overdose.[193]

125. Although Ms Haworth had been a police officer for considerably longer than Officer Reid, her (Ms Haworth's) experience with fatal incidents predominantly related to motor vehicle accidents.[194]

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[187] Exhibit 1, Tab 24, Incident Report 240219 1130 15766
[188] Exhibit 1, Tab 8.1, Memorandum - Const. M Reid (01.06.19)
[189] Exhibit 1, Tabs 29.1-29.4, Statement & Attachments - Ms J Haworth (undated) and ts 27.09.23 (Haworth), pp124-138
[190] Exhibit 1, Tabs 30.1-30.4, Statement & Attachments - Const. M Reid (20.09.23) and ts 26.09.23 (Reid), pp98-122
[191] Exhibit 1, Tab 26, Report - Inspector D Gorton (29.08.23) and ts 28.09.23 (Gorton), pp242-252
[192] Exhibit 1, Tab 23, Investigative Questionnaire for Child Fatalities
[193] ts 26.09.23 (Reid), pp98 & 102
[194] ts 27.09.23 (Haworth), p128

126. In any case, at the relevant time officers investigating child deaths were guided by the Western Australian Police Force (WAPF) Manual which contained a policy entitled "*SS-02.13.8 Child Deaths*" (Policy).[195] In passing, I note that the Policy has recently been updated and is now referred to as "*SS-02.27 Child Deaths*".[196]

127. Relevantly, the "*Introduction*" of the Policy includes the following statements:

> The investigation of the death of a child is an extremely complex area of police work, and is also very demanding for investigators in terms of emotional pressure; and
>
> Children are not meant to die, and the police investigation into the sudden death of a child must be influenced by this basic fact. **This means that even when there are no apparent suspicious circumstances, the police contribution to the investigation must be detailed and thorough**.[197] [Emphasis added]

128. The Policy also sets out "*risk factors for suspicion*", which are listed in "*priority of suspicion*". Five of those factors are directly relevant to the investigation of Child ML's death, namely:

> 5. Previous atypical hospital visits;
> 6. History of alcohol and/or drug abuse;
> 7. Child over one year;
> 8. Under the supervision of CPFS;[198] and
> 9. Known to CPFS.[199]

129. Under the heading "*Procedures*", the Policy sets out various tasks that attending officers are expected to undertake. In addition to arranging urgent medical assistance (where appropriate), officers are required to contact the on-call officer at the Homicide Squad when the child's death appears to be suspicious, or where "*criminality cannot be negated*".[200]

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[195] Exhibit 1, Tab 26.2, SS-02.13.8 Child Deaths (Effective 06.02.19), Procedures
[196] Exhibit 1, Tab 26.1, SS-02.27 Child Deaths (Effective 08.09.23)
[197] Exhibit 1, Tab 26.2, SS-02.13.8 Child Deaths (Effective 06.02.19), Introduction
[198] CPFS is the abbreviation for Child Protection and Family Services, the Department's predecessor
[199] Exhibit 1, Tab 26.2, SS-02.13.8 Child Deaths (Effective 06.02.19), Risk factors for Suspicion
[200] Exhibit 1, Tab 26.2, SS-02.13.8 Child Deaths (Effective 06.02.19), Procedures

130. The Policy provides that in the metropolitan area, officers from the Coronial Investigation Squad (CIS) are responsible for attending non-suspicious sudden or unexpected child deaths in the metropolitan area. However, in regional areas, the Policy requires officers attending a sudden and/or unexplained child death "*to contact the on-call duty inspector who will provide advice on the appropriate response*".[201]

131. The Policy makes clear that there is no requirement for "*first responders*" to obtain formal statements or conduct forensic examinations, as "*this should be conducted by CIS and specialist staff*". However, the Policy notes that attending police are not restricted from "*establishing the circumstances of the death through dialog with those present*", and that "*notebook entries (are) to be made of what was said and by whom*".[202] In this case, Officer Reid did exactly that, and a copy of her handwritten notes was attached to her statement to the Court.[203]

132. Although the Policy provides that CIS officers will contact the Department to determine whether the child or their family have any relevant history with the Department, this appears to be mainly relevant to deaths in the metropolitan area. In this case, the Officers contacted Crisis Care, and a staff member advised that they did not intend to arrange for any departmental staff to attend the scene and instead, were "*happy with (Ms B) being present during Police attendance*".[204]

133. At the inquest, Mr Mooney said he was surprised at the decision made by Crisis Care,[205] noting there was an on-call arrangement with local staff who are paid a small hourly rate "*for being available*". Mr Mooney also said that:

> If we had been called out, we would absolutely (have) seen it as appropriate that we do that from a support point of view".[206]

[201] Exhibit 1, Tab 26.2, SS-02.13.8 Child Deaths (Effective 06.02.19), Procedures
[202] Exhibit 1, Tab 26.2, SS-02.13.8 Child Deaths (Effective 06.02.19), Procedures
[203] See also: Exhibit 1, Tab 30.2, Handwritten notes Const. M Reid (24.02.19)
[204] Exhibit 1, Tab 8.3, Running Sheet: Incident Report 240219 1130 15766, p27
[205] Crisis Care provides an after-hours response to child safety concerns, and referrals for people experiencing crisis
[206] ts 28.09.23 (Mooney), p257

134. In this case, it appears that after Child ML was discovered deceased, Mr C contacted Ms B and she provided Ms McDonald's details to the Officers. In any event, Ms B, Ms McDonald and Ms Hall all attended the scene and assisted the Officers with their investigation.[207,208]

135. In this case, I accept that a significant difficulty faced by the Officers during their investigation was that Child ML's death occurred in a regional area. This meant that specialist staff, including forensic officers, were not readily available.

136. I also accept that at the relevant time, neither of the Officers had access to a physical copy of the Policy, although they were aware of its existence.[209] As I will explain later in this finding, a variety of policy documents are now becoming available to officers attending incidents, through an app known as *Hey Sarge*, which is installed on mobile phones which police are now issued with.[210]

137. During their investigation, the Officers spoke to attending ambulance officers, Ms A, Mr C, Mrs C, Ms B, and Ms McDonald. The Officers also took photographs of the scene and Child ML's medications, which were seized for analysis.[211,212,213]

138. However, I note that although a container of Panadol on a table in Child ML's bedroom was photographed, this medication was not seized, and was therefore not analysed.[214]

139. In addition, although Child ML's feeding bags and tubes were placed in the body bag in which she was transported to the State Mortuary, none of these items was the subject of any analysis and were subsequently disposed of. It also appears that although syringes found in Child ML's bedroom were photographed, they were not seized or analysed either.

[207] Exhibit 1, Tab 10, Statement - Mr C (30.05.19), para 48
[208] Exhibit 1, Tab 8.3, Running Sheet: Incident Report 240219 1130 15766, p27
[209] ts 27.09.23 (Haworth), pp127-129
[210] Exhibit 1, Tab 26, Report - Insp. D Gorton (29.08.23), p5 and ts 28.09.23 (Gorton), p253
[211] Exhibit 1, Tab 25, Photographs of Child ML's bedroom and medications taken by Officer Reid (24.02.19)
[212] Exhibit 1, Tab 30.3, List of photographs taken by Officer Reid (24.02.19)
[213] Exhibit 1, Tab 30.4, Photographs of Child ML's bedroom and medications, taken by Const. M Reid (24.02.19)
[214] Exhibit 1, Tab 30.4, Photographs of Child ML's bedroom and medications taken by Const. M Reid (24.02.19)

140. As noted, the Policy requires officers attending a child death in regional areas to contact the on-call duty inspector for advice.[215] In this case however, Ms Haworth contacted the Officer-in-Charge of the Australind police station, as well as the office of Bunbury Detectives for guidance.[216] Obviously because it didn't happen in this case, it is impossible to know whether the Officers' investigation would have taken a different course had the on-call duty inspector been contacted.

141. In any case, after Ms Haworth conveyed her impression of the scene to the officers she did contact (including her assessment that Child ML's death appeared to be non-suspicious), Ms Haworth was advised that she and Officer Reid should retain carriage of the investigation, and that detectives would not be attending.[217]

142. Despite the positive aspects of the Officers' investigation to which I have just referred, in my view, it is very unfortunate that Child ML's feeding bags, syringes, and tubes were not seized for analysis. At the inquest, Ms Haworth said she had assumed that this analysis would occur automatically, although the basis for her assumption is unclear.[218]

143. In my view, it is also unfortunate that Child ML's feeding bags and tubes were disposed of at the State Mortuary before being tested, notwithstanding the fact that at that time, the results of the toxicological analysis of samples from Child ML's body had not yet been received.[219]

144. At the conclusion of the Officers' investigation, Officer Reid finalised a report for the coroner in which she noted :

> Toxicology and formal neuropathology has been requested, however to-date the report findings have not been received by the investigating officer. The deceased was a 7-year old child who had battled a terminal illness since birth, namely Spastic Quadriplegia - ex 28/40 with twin to twin transfusion. I have found no suspicious circumstances in her passing. This concludes my inquiries into the death of (Child ML), subject to further direction from the Coroner.[220]

[215] Exhibit 1, Tab 26.2, SS-02.13.8 Child Deaths (Effective 06.02.19), Procedures
[216] ts 27.09.23 (Haworth), pp129-132 & 136 and see also: ts 26.09.23 (Reid), p102
[217] ts 27.09.23 (Haworth), pp129-132 & 136
[218] ts 27.09.23 (Haworth), pp132-135
[219] Exhibit 1, Tab 6.3, Emails Dr J White (8.24 am, 16.05.23 and 10.06 am, 16.05.23) and ts 27.09.23 (White), pp196-200
[220] Exhibit 1, Tab 8.1, Report - Const. M Reid (01.06.19), pp6-7

Subsequent investigation[221,222]

145. Following Professor Joyce's analysis of Child ML's toxicological results, Detective Sergeant Gareth Reed (Officer G Reed) was asked to conduct further enquiries into the circumstances of Child ML's death. Officer G Reed reviewed the available documentary evidence, and also confirmed with Dr Ley that Child ML had not been prescribed any medication containing codeine at the time of her death.

146. As noted, none of the medication the Officers seized at Mr and Mrs C's home was found to contain codeine, although as Officer G Reed properly noted in his memorandum:

> It does not appear as though an extensive search was conducted for any medications in the residence given (Child ML's) history. The prevailing inference at the time was that this matter was a non-suspicious death.[223]

147. At the inquest, Officer Reid confirmed that the search of Mr and Mrs C's home had been confined to Child ML's bedroom. This leaves open the possibility that medication containing codeine may have been located in another part of the house, and I note that Mr C recalled that at the relevant time, there were some cold and flu tablets in a zip-up bag under the bathroom sink. Mr C said these tablets "*could have contained codeine*", but he wasn't "*too sure*" if this was the case.[224,225]

148. As to the fate of Child ML's feeding bags and tubes, in his memorandum Officer G Reed noted:

> Inquiries with Dr Jodi White reveal that the feeding bags came with (Child ML) to the mortuary, however (they) appear to have been destroyed without further analysis. This has unfortunately created an evidence gap as any codeine administered to (Child ML) would likely have shown some evidence within these bags. That being said, again, there was no apparent reason at the time to have these bags tested.[226]

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[221] Exhibit 1, Tab 8.2, Memorandum - Det. Sgt. G Reed (11.05.23) and ts 27.09.23 (Reed), pp217-224
[222] Exhibit 1, Tab 8.3, Running Sheet: Incident Report 240219 1130 15766
[223] Exhibit 1, Tab 8.2, Memorandum - Det. Sgt. G Reed (11.05.23), p2
[224] ts 26.09.23 (Reid), pp110-111; ts 26.09.23 (Mr C), pp49-50; and see also: ts 26.09.23 (Mrs C), pp68-70
[225] See also: Exhibit 1, Tab 11, Statement - Mrs C (25.05.23), paras 57-59
[226] Exhibit 1, Tab 8.2, Memorandum - Det. Sgt. G Reed (11.05.23), p2

149. In an email dated 16 May 2023, Dr White confirmed that: "*Given that the case was not considered suspicious at that time, I recorded the feeding bag was present but I did not sent it for analysis. The bag must have been discarded*". In an email sent later the same day, Dr White also said: "*It* (i.e.: the feeding bag) *has not been kept as there is no record of it being stored*".[227]

150. In his memorandum, Officer G Reed confirmed that he interviewed "*all relevant witnesses involved in* (Child ML's) *day to day care or within proximity of her at the time of her death*" and noted that none of these witnesses (i.e.: Ms A, Mrs C, or Mr C) had "*reported administering any codeine medications to (Child ML)*".[228]

151. Further, Ms A had said that in addition to giving Child ML her prescription medication, Ms A also gave her "*a half a tablet of soluble Panadol dissolved in water and a standard dose of liquid Nurofen*" through Child ML's "*feeding tube*".[229,230] However, Ms A told Officer G Reed she did not possess any medication containing codeine and in fact, because she had experienced nausea when she had taken codeine in the past, she "*would opt for other forms of medication*".[231]

152. Officer G Reed also noted that enquiries he conducted with Medicare had confirmed that since 1 January 2018, neither Child ML, Ms A, Mr C, nor Mrs C had been prescribed medication containing codeine.[232,233,234]

153. After completing his investigation, Officer G Reed expressed the following conclusions in his memorandum:

> I am unable to determine definitively the source of the codeine present in (Child ML's) body at the time of her death. I am unable to substantiate the method by which codeine was introduced to (Child ML), nor whether it was accidental or intentional in nature.[235]

[227] Exhibit 1, Tab 6.3, Emails Dr J White (8.24 am, 16.05.23 and 10.06 am, 16.05.23)
[228] Exhibit 1, Tab 8.2, Memorandum - Det. Sgt. G Reed (11.05.23), p2
[229] Exhibit 1, Tab 8.2, Memorandum - Det. Sgt. G Reed (11.05.23), p2
[230] See also: ts 26.09.23 (Mr C), pp51-53 and ts 26.09.23 (Mrs C), pp68 & 77-78
[231] Exhibit 1, Tab 8.2, Memorandum - Det. Sgt. G Reed (11.05.23), p2
[232] Exhibit 1, Tab 8.2, Memorandum - Det. Sgt. G Reed (11.05.23), p2
[233] Exhibit 1, Tab 22, Services Australia: Certificate authorising disclosure of protected information(07.08.20)
[234] Exhibit 1, Tab 22, Medicare Reports and PBS Summary - Child ML, (07.08.20)
[235] Exhibit 1, Tab 8.2, Memorandum - Det. Sgt. G Reed (11.05.23), p3

Comments on police investigations

154. I making the following observations about the police investigation of Child ML's death, I have been mindful not to insert any hindsight bias into my assessment of the actions taken by the Officers. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[236]

155. As noted, the information the Officers were given by the police CAD system, included the words: "*Expected death as child was terminal*". In my view, these words clearly suggest that Child ML's death was due to "*natural causes*", and this appears to have influenced the approach taken by the Officers during their investigation. As Officer Reid noted in the following exchange with Counsel Assisting at the inquest:

> *Ms Markham*: If somebody had told you that information at the scene, this child had a terminal illness and was given a life expectancy of three to four years, and…the child is seven, would that, do you think, have factored into your assessment that this was probably a natural causes death?
>
> *Officer Reid*: Absolutely…To me, you know, that reads that she has already lived longer than what she was expected to.[237]

156. The practical consequence of approaching Child ML's death as non-suspicious was that a key line of enquiry, namely the analysis of the contents of Child ML's feeding bags and tubes, was not pursued. In my view, it is clearly unfortunate that Child ML's feeding bags and tubes (and the syringes found in her bedroom) were not seized and analysed. Had this occurred, it may have been possible to determine how Child ML was given the codeine that was strongly implicated as having contributed to her death.

157. In making that observation, I accept that the investigation of a child's death is a particularly distressing task, and that the scene at Mr and Mrs C's home immediately following Child ML's death would have been chaotic and emotionally charged.[238]

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[236] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015), p10
[237] ts 26.09.23 (Reid), p106
[238] ts 26.09.23 (Reid), p99

158. Nevertheless, at the time of her death, Child ML was seven years of age, and she was in the care of the Department. Child ML was also having a period of supervised contact with Ms A, a known user of methylamphetamine. In those circumstances, and given the plain words of the Policy, it is clearly unfortunate that none of these factors triggered a greater level of inquisitiveness on the part of the Officers.

159. It is also unfortunate, given that Child ML was fed entirely by means of feeding bags and tubes, that this fact did not provoke a "*detailed and thorough*" investigation (to use the words of the Policy) of the possible causes of Child ML's death, and/or whether there was anything in her feeding bags or tubes that there shouldn't have been.

160. In that context, I was troubled by the statement in Officer G Reed's memorandum that: "*there was no apparent reason at the time to have these bags tested*". In my view, for the reasons I have identified (and given the plain words of the Policy), there was every reason why this should have occurred.

161. At the inquest, although Officer Reid asserted that she and Ms Haworth had completed their investigation "*to our best ability at the time*", she accepted (with the benefit of hindsight) that Child ML's feeding bags and tubes should have been seized for analysis. Officer Reid also said she would have pressed for detectives to have attended the scene.[239]

162. I also note that at the inquest, both Officer G Reed and Inspector David Gorton (Officer Gorton) agreed that with the benefit of hindsight, Child ML's feeding bags and tubes should have been seized by the Officers and analysed.[240]

163. For the sake of completeness, I note that I was also troubled by a response Officer G Reed gave when I asked him about the level of inquisitiveness that the Officers should have had about the contents of the feeding bags and tubes attached to Child ML.

[239] ts 26.09.23 (Reid), pp105-115
[240] ts 27.09.23 (Reed), p223 and ts 28.09.23 (Gorton), pp250-252

164. At the inquest, after Officer G Reed expressed his opinion that even if detectives had attended the scene, Child ML's death would still "*have been a non-suspicious outcome*",[241] the following exchange took place:

> *Coroner Jenkin:* Even given that, wouldn't it - I mean, obviously I'm a layperson as far as police investigative techniques are concerned, but you wouldn't have to have a very high level of inquisitiveness to wonder, gee, I wonder what's in those feeding bags. It looks like clear liquid. It's going into the child. The child is dead. I wonder what's in there.
>
> *Officer G Reed:* I don't think that's necessarily correct. **Things are non-suspicious until they're suspicious, I guess, for want of a better term.** We roll up at a scene, and I'm talking about this from a detective's investigative point of view. We would come to the scene. We would try and interview witnesses. I think we would have come to the same outcome. So I think…and a child with (Child ML's) medical conditions who clearly from the information at the scene was being fed by those bags, there was nothing at the scene to indicate that there was any medications being received that she shouldn't have been. And her death, while sudden, was not unexpected, given her medical conditions.[242] [Emphasis added]

165. With great respect, in my view it should be patently obvious that the death of any vulnerable person (especially a child), should be regarded as suspicious until the contrary has been unequivocally established. This much is consistent with the plain words of the Policy, and in any case, if police investigators were to approach the investigation of a child death in any other way, there would be too great a risk that, as happened in Child ML's case, potentially valuable evidence might be inadvertently discarded.

166. In my view, had the precise circumstances surrounding the administration of codeine to Child ML been established, it is inevitable that further investigations would have been undertaken by police. In that context, there is at least a possibility that criminal charges against some person might have been considered.

[241] ts 27.09.23 (Reed), p220
[242] ts 27.09.23 (Reed), pp220-221

167. However, the "*prevailing inference*" at the relevant time was that Child ML's death was non-suspicious, and as I have observed, this mindset led to the potential significance of key pieces of evidence (e.g.: the contents of Child ML's feeding bags) being overlooked. This outcome is clearly unsatisfactory, and has meant that the opportunity to potentially determine how Child ML was given such a large dose of codeine (and paracetamol) in the period before her death has long since evaporated.

168. In making these observations, I take account of the information that was available to the Officers at the relevant time, as well as the guidance they received from their superiors, including the detectives Ms Haworth consulted. I also accept that neither of the Officers had previously attended a child death, and that information about Child ML's expected lifespan suggested her death had occurred by "*natural causes*".[243]

169. After carefully considering the available evidence, I have decided it is not necessary for me to make any adverse findings in relation to the investigation conducted by the Officers. Instead, I merely repeat my earlier observation that it is unfortunate that Child ML's feeding bags, syringes, and tubes were not seized and analysed.

170. As I have noted, at the inquest, Officer Reid acknowledged that with the benefit of hindsight, Child ML's feeding bags and tubes should have been seized for analysis. Officer Reid also agreed that had this occurred, it may have been possible to pursue further lines of enquiry into the circumstances of Child ML's death.[244] In my view, this demonstrates a pleasing capacity to learn from previous errors or oversights.

171. At the inquest, I suggested PathWest and the WAPF consider developing a protocol to ensure that all relevant items at the scene of the death of a vulnerable person (including a child) were seized and analysed. The aim of the protocol would be to ensure that relevant items at the scene of the death were analysed to determine their relevance (if any) to the death. Officer Gorton expressed support for this suggestion,[245] and the WAPF subsequently accepted the recommendation I made in this regard.

[243] ts 26.09.23 (Reid), pp106-107
[244] ts 26.09.23 (Reid), pp105-115
[245] ts 28.09.23 (Gorton), p249

IMPROVEMENTS SINCE CHILD ML'S DEATH

Enhancements made by WAPF[246]

172. At the inquest, Officer Gorton noted that since Child ML's death, police are now issued with mobile phones so that their ability to capture images of a scene has improved. Officer Gorton also noted that an app known as *Hey Sarge,* which is under development, is installed on the mobile phones issued to officers.

173. Following a series of incremental "*roll outs*" which are currently underway, a range of policy and procedural information will become progressively available on *Hey Sarge* for the guidance of officers attending incidents, including sudden unexplained child deaths. Officer Gorton also noted that the Policy has been recently updated to incorporate "*our level of training, technology updates, (and) procedures which make it easier or better for us to do our job*".[247]

174. In his report Officer Gorton acknowledged that not all police officers have "*a complete knowledge of the processes and procedures required in responding to infant and child deaths*". Officer Gorton said for that reason, automated messages are generated in the CAD system for certain job categories, including sudden deaths. Since 2019, these automated messages have been updated "*to reflect changes to policy, and technology advancements*".[248,249]

175. Officer Gorton also noted that in 2018, the Superintendent responsible for the South West District (which includes Australind) had issued a "*broadcast*" to officers under his command "*outlining additional duties to be followed regarding attendance at sudden deaths*". The Superintendent's broadcast included the requirement that attending officers contact "*the local detectives' office and/or the Duty Inspector depending on the time of day*".[250,251]

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[246] Exhibit 1, Tab 26, Report - Insp. D Gorton (29.08.23) and ts 28.09.23 (Gorton), pp242-253
[247] ts 28.09.23 (Gorton), p243
[248] Exhibit 1, Tab 26, Report - Insp. D Gorton (29.08.23), p4
[249] Exhibit 1, Tab 26.7, CAD messaging example - Sudden death/Child Death (August 2023)
[250] Exhibit 1, Tab 26, Report - Insp. D Gorton (29.08.23), p5
[251] Exhibit 1, Tab 26.5, Annexure 5: Broadcast 4/2018, South West District, Sudden Death - Detective Oversight

Enhancements made by the Department[252]

176. In his report to the Court, and at the inquest, Mr Mooney referred to a number of improvements the Department has made since Child ML's death, including:

a. *Policy enhancements*: in mid-2020, the Department transitioned to stability and connection planning. Although reunification continues to be emphasised as the primary goal, this now occurs "*within a parallel planning process*" that includes culturally appropriate, stable out of home care options for children who cannot be safely returned to their parents.

   Information and training on the features of the new policy (including new flexibility in relation to decision making timeframes) was delivered to staff between February and August 2020, and practice clinics to enhance regional practice are planned for the second half of 2023.[253]

b. *Regional intensive support coordination*: the program, which was approved in December 2020, aims to support people with complex disability support needs (and where appropriate, their families) to access suitable support options in their local area.

c. *Health navigator program*: this program (which is being piloted in Mirrabooka and in the South West):

   > [A]ims to improve health outcomes for children and young people in out of home care by ensuring they receive timely and comprehensive health assessments focussed on their need for physical, mental, developmental, disability, and social and emotional cultural support.[254]

   The pilot program has seen two health navigators employed in each of the pilot locations. These staff provide wrap around care and coordinate access to health care and other services and liaise with other agencies.

[252] Exhibit 1, Tab 15.2, Report - Mr B Mooney (18.09.23), pp1-8 and ts 28.09.23 (Mooney), pp254-269
[253] See also: Exhibit 1, Tab 15.2, Attachment 2, 3.4.15 Stability and connection planning
[254] Exhibit 1, Tab 15.2, Report - Mr B Mooney (18.09.23), p3

Health navigators review the needs of supported children and "*facilitate training for a parent or carer where training is available*".[255] At the inquest, Mr Mooney agreed that health navigators may have been able to coordinate the delivery of training about Child ML's needs to Ms B, and Mr and Mrs C.[256] Further, in an email, Ms Femia confirmed:

- The State Government committed $3.5 million over two years to the Department of Health for the Health Navigator Pilot Program (Program);
- The Program is funded until the end of the 2023/2024 financial year; and
- Subject to ongoing positive evaluation of the Program and usual budget processes, the Program could be extended past its current funding period.[257]

d. *Foster carer refresh project*: in partnership with the Foster Carer Association of Western Australia, the Department established the Foster Carer Refresh Project, which aims to:

> [I]mprove the outcomes for children in care by working with foster, family, and significant other carers, and the sector".[258]

e. *Safety plan review*: a review of safety planning in the Department's child protection practice was commissioned in October 2022, and a report is expected in the second half of 2023. The review aims to examine "*strengths and challenges*" in current practice to assist with the strengthening of systems and processes, develop additional resources for case workers, and enhance training and professional development.

f. *Signs of safety training*: the Department engaged Elia (a not-for-profit organisation) to deliver safety planning training to its "*child protection workforce*". The training, which began in May 2023, will continue in 2024.

[255] Exhibit 1, Tab 15.2, Report - Mr B Mooney (18.09.23), p3
[256] ts 28.09.23 (Mooney), pp258-259
[257] Email - Ms P Femia (06.10.23)
[258] Exhibit 1, Tab 15.2, Report - Mr B Mooney (18.09.23), p4

177. At the inquest, Mr Mooney acknowledged the difficulties which the Department had experienced in recruiting suitably skilled family resource workers, especially in the South West. However, Mr Mooney noted that the wages paid to family resource workers have now increased after the role was reclassified in recognition of the increasing expectations placed on the staff performing these roles.[259]

178. Mr Mooney also noted that his District had recently obtained funding to employ a family support coordinator, who will support the District's family resource workers, and provide them with individual supervision, something which has not been able to be provided to date. Mr Mooney said he expected the coordinator role would "*result in significant improvements*" to the region's family support worker service.[260]

179. In an email dated 28 September 2023, Ms Femia confirmed her instructions were that since 2020 an additional 19.7 full time equivalent (FTE) child protection workers, and an additional 4.6 FTE placement support workers have been employed in the South West District.[261]

180. Finally, I note that in her statement, Ms Hall noted that:

> There have been beneficial changes made to processes locally within the South West District. For example, all decisions for reunification cases to move to unsupervised contacts with parents are now reviewed and approved by the District Director.[262]

[259] ts 28.09.23 (Mooney), p256
[260] ts 28.09.23 (Mooney), p257
[261] Email - Ms P Femia to Ms S. Marham (28.09.23)
[262] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), para 46 and ts 27.09.23 (Hall), pp211-212 & 215

RECOMMENDATIONS

181. In view of the observations I have made in this finding, I make the following recommendations:

Recommendation 1

I recommend that the Western Australian Police Force and PathWest develop a protocol or procedure to deal with the analysis of items (including medication, syringes, feeding bags, tubes etc) seized at the scene of the death of a vulnerable person, including a child.

The aim of the protocol or procedure would be to ensure that all relevant items at the scene of the death are seized and analysed, so as to determine what relevance (if any) the items have to the death.

Recommendation 2

The Department of Communities consider offering, at no cost, first aid training to the carers of children with complex medical needs, and to persons who provide support and supervision for such children during access visits with the child's significant others.

Recommendation 3

The Department of Communities (the Department) should strengthen the oversight process for members of the safety network of children in care who have complex medical needs.

Further, in order to ensure that members of the child's safety network who are expected to supervise the child's care during access visits with the child's significant others can do so competently, the Department should ensure that those persons are provided with education, and information about the child's care needs.

Comments on recommendations

182. In accordance with my usual practice, on 29 September 2023, Ms Markham forwarded a draft of the recommendations I intended to make to Ms Femia and Ms Panetta. Counsel were asked to forward any comments their client's may have on the draft recommendations, to the Court, by close of business on 13 October 2023.[263]

183. By way of an email dated 13 October 2023, Ms Femia advised that the response of the WAPF to Recommendation 1 was as follows:

> WA Police Force supports this recommendation and through the Unexplained Deaths Meeting, an appropriate protocol will be established in relation to non-suspicious vulnerable deaths (full scope to be determined) to ensure all potential evidence is seized at the earliest opportunity.[264]

184. By way of a further email dated 13 October 2023, Ms Femia advised that the Department's response to Recommendations 2 and 3 was as follows:

a. *Recommendation 2*: the Department supported this recommendation, and noted that:

> Communities' Learning and Development Directorate offer face-to-face First Aid Training delivered via Heartbeat Club, Royal Life Saving Western Australia, for foster carers. The training is delivered in the metropolitan area at least four time a year with a maximum 20 people per course.

b. *Recommendation 3*: the Department advised it supported this recommendation. I have adopted the sensible amendment suggested by the Department, which was designed to more closely align the recommendation with departmental practice.[265,266]

[263] Email - Ms S Marham to Ms P Femia and Ms R Panetta (29.09.23)
[264] Email - Ms P Femia to Ms S. Marham (13.10.23)
[265] Email - Ms P Femia to Ms S. Marham (13.10.23)
[266] Letter - Department of Communities (13.10.23)

CONCLUSION

185. Child ML was "*a complex but beautiful young girl of 7 years with the most amazing smile*".[267] She also had very complex care needs due to her numerous medical conditions. As a result of the limitations imposed on her by the issues she was grappling with, Ms A was demonstrably unable to provide Child ML with the level of care that Child ML clearly required.

186. Whilst that does not mean Child ML was not dearly loved by Ms A, it does mean that the Department's decision to take Child ML into care was clearly correct. I also note Ms Hall's assessment in her statement to the Court, that:

> (Ms A's) amicable and courageous decision, to not manage the care of Child ML on her own but with a shared care arrangement, was insightful and child focussed.[268]

187. After carefully considering all of the available evidence, I concluded that Child ML's foster carer (Ms B), had managed Child ML's complex care needs in a diligent, skilled, and caring manner. Ms B also provided Child ML with a stable and loving home, in which she clearly thrived.

188. In my view, it is noteworthy that at the time she assumed responsibility for Child ML's care, Ms B was looking after children of her own. Clearly, Ms B is to be highly commended for her willingness to take on responsibility for Child ML's very complex care needs, and for fulfilling those responsibilities in such a competent and caring manner.

189. At the time she died, Child ML was having a supervised access visit with Ms A. As I have explained, Child ML was found to have a number of medications in her system, including high levels of paracetamol and gabapentin, and an overdose of codeine. Child ML was not prescribed codeine, and it is clearly unsatisfactory and frustrating that on the basis of the available evidence, I have been unable to determine how and/or why Child ML came to have codeine in her system.

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[267] Exhibit 1, Tab 19, Report - Dr B Ley, Bunbury Hospital (05.03.19), p1
[268] Exhibit 1, Tab 28, Statement - Ms H Hall (20.09.23), para 46

190. The people who had access to Child ML in the period leading up to her death (i.e.: Ms A, Mr C and Mrs C) all flatly denied having given her any medication containing codeine (even inadvertently). Nevertheless, despite these denials, the evidence establishes that the levels of codeine and morphine detected in Child ML's system were "*strongly implicated*" as having contributed to her death, and had come from a large dose of codeine which was given to Child ML a few hours before her death.

191. Regardless of how, and why codeine (and paracetamol) was given to Child ML, the fact that she was found to have such high levels of these medications in her system clearly establishes that the level of care and supervision Child ML received from Ms A in the period leading up to her (Child ML's) death was woefully inadequate.

192. After carefully considering all of the available evidence, I also concluded there were inadequacies in the standard of supervision and support provided to Child ML, and her carers whilst she was in the Department's care. This included inadequacies in the support provided to Ms B generally, and to Ms A during supervised and unsupervised contact visits with Child ML.

193. In conclusion, as I did at the inquest, I wish to again convey to Child ML's loved ones, including Ms B, on behalf of the Court, my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner
10 November 2023