Coroners Act, 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 16/13

I, Alastair Neil Hope, State Coroner, having investigated the deaths of ***Malachi Isaac STEVENS and Lochlan James STEVENS****, with an Inquest held at Perth Coroners Court on 29 April 2013 – 10 May 2013 find that the identities of the deceased persons were* ***Malachi Isaac STEVENS and Lochlan James STEVENS*** *and that both deaths occurred on the night of 7-8 November 2008 at 62 Coniston Drive, Ellenbrook, as a result of Unascertainable Causes in the following circumstances -*

Counsel Appearing :

Ms Kate Ellson assisting the State Coroner
Mr Michael Clarke (instructed by Legal Aid) appeared for Ms Miranda Hebble

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INTRODUCTION

Malachi Isaac Stevens and Lochlan James Stevens both died on the night of 7-8 November 2008. At the time of their deaths Malachi was 10 months of age, having been born on 4 January 2008, and Lochlan was 2 years of age, having been born on 13 June 2006.

At about 1.32am on the morning of 8 November 2008 the mother of the deceased children, Miranda Lee Hebble, rang 000 and told the operator:

> I passed out and my babies are in the shower and the door closed and they are dead (Crying, deep inhale).

Later in the same call Ms Hebble and the operator took part in the following discussion:

> I'm telling you. I was in the shower today.
>
> Yes.
>
> And (breath) I passed out and (crying, inaudible).
>
> Stop. Stop. Stop. You passed out. You had. You were in the shower and you passed out?
>
> Uh. Uh. Yeah I passed out (deep breath) and the plug (rattling noise) in the shower got plugged up.
>
> Yep, and you have flooded the place, have you?
>
> And the baby's dead.

During the same call Ms Hebble told the operator that she and the children were at her home at 62 Coniston Drive, Ellenbrook, and then she made the following statement:

> They're not breathing, they're dead, I (inaudible, crying) passed out at 2 o'clock today and I only just woke up. (crying).

According to Ms Hebble both of her children died in the en suite bathroom of her home in Ellenbrook. Although her various accounts given at different times shortly after the event were not identical, in a statement which she provided to police on 11 November 2008 (she declined to take part in a video recorded interview with police after speaking with her lawyer, Michael Clarke) she stated that she put both boys in the shower about ten minutes after she received a telephone call from her partner, Christopher James Stevens.

That telephone call, based on telephone records, appears to have taken place at about 3.24 pm.

If this account is accurate, the boys were in the shower at about 3.24pm and in the en suite from that time until shortly before the 000 call, at 1.32am, a period of about 10 hours.

Ms Hebble claimed that she turned the taps on in the shower in the en suite and both boys *"sat in the bottom of the shower"*. She said that she then *"blacked out"*. In her statement she said, *"I saw white speckle things and then passed out. I woke up because I felt water on my feet"*.

She said that she then opened the door to the en suite and found her baby, *"floating in the shower"*. It appears clear that this was Malachi. She said that her other "baby" was on the bathroom floor. It appears clear that this was Lochlan.

She said that there were bits and pieces clogging up the drain in the shower so she pulled these away from the drain hole and turned the shower, which was still running, off.

She claimed that she then took the two children out of the en suite and put them on the carpet near the kitchen in the meals area of the home.

Clearly the circumstances in which two young children could die in an en suite bathroom were concerning.

A subsequent post mortem examination conducted on the two children was somewhat disappointing in that no clear cause of death in either case was identified, but there were further aspects of the post mortem examination which were of concern.

This inquest was held to examine the circumstances of the deaths of these two children.

Results of the medical examination of the body of Malachi Stevens

Malachi Stevens was examined by Forensic Pathologist, Dr Jodi White, on 10 November 2008.

Following the results of all investigations, on 29 September 2009 Dr White formed the opinion that the cause of death was unascertainable.

Dr White observed that drowning in forensic pathology terms is a diagnosis of exclusion and a death could only be considered as being consistent with drowning if all other relevant natural or non natural causes within reason could adequately or sufficiently be excluded. She was unable to determine whether or not Malachi had drowned.

A concerning feature in Malachi's case was the fact that prior to his death he had been failing to thrive.

During the course of ongoing investigations Dr White became aware of Malachi's birth weight and his weight at seven weeks of age. These were compared with his weight at the time of death.

Malachi's various weights and his length were charted on the Weight Percentile and Length Percentile for boys 0-3 years of age. These are charts used to monitor growth of boys at different ages and the reference to the percentile is

to the percentage of children at lower weight or length at the same age.

In respect of his weight, Malachi at birth was 3.690 kg and was above the 50th percentile, after seven weeks he weighed 6.25 kg and then was in about the 95th percentile (or heavy for his age), while at death at 10 months of age he only weighed 7kg and his comparative weight had dropped to below the third percentile. This drop in expected weight was extremely significant.

Malachi's length was only measured on two occasions, at birth his length was 50cm, while at death his length was only 70cm. In respect of length he had dropped from the 50th percentile to well below the 25th percentile relative to boys of the same age.

This failure to grow as expected, particularly with his weight going under the third percentile, was an alarming development.

Dr White gave evidence that this deterioration in his condition indicated that either he was not getting enough food or he was not able to absorb the food.

This matter was referred to Dr Peter Winterton, a general practitioner with 35 years experience, who

discussed the significance of these findings in the following exchange:

> Now in respect of these measurements, assuming that they're accurate, and for a start they're clearly consistent in that they're showing a deterioration in his condition?---Yes.
>
> They're showing alarming deterioration in his condition?---Yes.
>
> That deterioration, is that something that could result from just a relatively short period of days, or is this something that would have taken weeks or even months?---Well, no, it wouldn't be days. Well, I can't comment on days because there's obviously nothing in between.
>
> Yes?---So I don't know where the dots would have been between. But on the growth chart that is in front of me, this has obviously occurred over eight months that there's been a fall below the third centile and by anyone's standard this is concerning as to why. Now, there are many reasons why, of course, children fall below the third centile, but from a – I mean again if this child were to present with this sort of history to a general practitioner, or to the hospital, the emergency department, outpatients, one would start to investigate as to what else is going on in this kid.

A further concerning feature of this case was that investigations revealed that Malachi had not been taken to a doctor in the months before his death and, indeed, he had not been taken for his required six month immunisation.

Had he been taken to a doctor it is likely that he would have been admitted into a hospital and a number of tests would have been conducted to ascertain why he was failing to thrive.

The external examination of Malachi revealed some minor injuries and significant lividity staining to the front of his body.

When Malachi and Lochlan were located in the house by ambulance officers and police they had then been placed on their backs. The fact that in Malachi's case lividity was to the front of his body indicated that he had been on his front for a significant period after death prior to the arrival of ambulance and police officers.

According to Dr White, while lividity usually starts anywhere from half an hour to two hours after death, it does not start to become fixed until between eight and twelve hours after death. In the case of Malachi as the lividity was mostly to the front of his body, this indicated that he must have been in the face down position for a least several hours after death and probably more.

In addition in Malachi's case there was evidence of early decomposition which was not present in Lochlan's case. It appeared likely that of the children, Malachi had died first.

Changes to the hands and feet were in keeping with prolonged contact with water. There were a number of scattered soft tissue injuries to the face and scalp, back of the torso and upper and lower limbs but none of these

appear to have been particularly significant in the context of the cause of death.

Results of the medical examination of the body of Lochlan Stevens

Lochlan Stevens was examined by Forensic Pathologist, Dr Jodi White, on 10 November 2008. Following receipt of results of further investigations on 29 September 2009 Dr White formed the opinion that the cause of death in his case was unascertainable.

In the case of Lochlan Stevens again there was lividity to the front of the body which indicated that he had been in a face down position for at least several hours prior to being moved before the arrival of ambulance officers and police.

In his case there was some staining seen on his back which suggested that not all of the pooled blood had become fixed prior to his being moved.

In his case also there were changes in keeping with prolonged contact with water, particularly on the backs of his hands and the backs of his fingers and on the feet, especially the soles of the feet.

Assuming that Lochlan had been lying face down in the en suite with the soles of his feet facing upwards, this indicated that the level of the water in contact with his body was relatively fairly deep.

OBSERVATIONS OF THE HOUSE WHERE THE DECEASED WERE LOCATED.

When police examined the house in which the deceased were located at 62 Coniston Drive, Ellenbrook, they discovered that the house was in an extremely dirty and untidy state.

Dirty clothes were in piles in different rooms in the house and soiled nappies were seen in a number of locations.

There were a large number of items on the floor of the en suite bathroom including a number of soiled nappies and items which Mr Stevens claimed would not normally be in the bathroom.

The bedroom in which the children normally slept was particularly dirty with faeces on the floor and evident in various locations in the room including on a cot, on sheets in the cot and on a wall and power point.

The general condition of the house suggested that Ms Hebble had been unable to cope adequately with normal

domestic tasks and the environment was an unhealthy one for young children.

INCIDENT OF FRIDAY 15 FEBRUARY 2008

At about 1.50pm on 15 February 2008 police officers stationed at Ellenbrook Police Station were tasked to attend the Woodlake Shopping Centre, Ellenbrook, under priority.

They were advised that an infant had been located alone in a vehicle by a member of the public.

That infant was Malachi Stevens, who at the time was only five weeks of age.

The police officers were Constables Kay McKenna and Daniel O'Rourke.

As the officers approached the vehicle a member of the public advised them that the infant was still in the vehicle and had been there for some time.

Constable McKenna (who at the time of inquest was a Detective First Class Constable) approached the vehicle and opened the rear door. The vehicle was not locked and all of the windows were closed. The engine was not running and the keys were not in the ignition.

When Constable McKenna opened the door she immediately felt heat coming from the inside of the vehicle.

The air conditioning was not on and the outside temperature was hot.

At the time Malachi was distressed and crying and appeared lethargic. He was sweaty and clammy to touch and his face was red in colour.

Constable McKenna took Malachi into the Liquorland store at the shopping centre to get him into air conditioning and requested some cold water.

Constable McKenna gave Malachi some water shortly after which Malachi's mother, Ms Hebble, came running into the store.

She apologised for leaving the baby in the vehicle and stated that she had only been gone for a few minutes.

That claim was inconsistent with the period the police had been involved and with the account given by a member of the public to the effect that Malachi had been left alone in the vehicle for about twenty minutes.

Constable McKenna asked Ms Hebble whether she was coping with the new infant as she appeared to be tired to

which Ms Hebble responded that she left the infant in the vehicle because she was so tired that she thought she might drop him if she was carrying him around the shops.

Constable McKenna asked Ms Hebble if she had spoken to a doctor and she stated that she was going to the doctor that day to get sleeping tablets to enable her to sleep.

Constable McKenna, who was clearly a concerned and conscientious police officer, said in evidence that she could remember the incident, *" ... Like it was yesterday, that mother was in crisis".* [2]

Constable McKenna was so concerned about the situation that when she returned to the police station she immediately prepared an incident report and notified the Department for Community Development (now the Department for Child Protection and Family Support) that she had concerns for the family.

Constable McKenna was concerned that Ms Hebble appeared to be extremely tired and did not appear to know what she had been doing or how long she had left the infant in the car. Constable McKenna noted that members of the public had said they had waited for a lengthy period of time and then called police, but Ms Hebble had insisted that she had only been gone for *"a couple of minutes".*

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[2] t 139

At about 2.40pm on the same day Ms Hebble telephoned Ellenbrook Police Station and spoke to Constable McKenna about the incident. She thanked the police officers for their assistance and stated that she had attended her doctor for treatment.

It appears that this was not in fact true and Ms Hebble had not sought assistance from any medical practitioner.

Ms Hebble was seen by officers of the Department for Community Development on 20 February 2008 when she appeared remorseful and assured them that this would never occur again.

This incident in February 2008 when Malachi was only five weeks of age is particularly concerning in the context of the circumstances of the deaths on 7-8 November 2008. Clearly Malachi could have died when left alone in a hot motor vehicle in the car park of a shopping centre.

EVENTS OF THE EARLY MORNING OF 8 NOVEMBER 2008 AND THE SUBSEQUENT POLICE INVESTIGATIONS

Senior Constable Tracey Hall and Constable Adrian Payne of the Ellenbrook Police Station were the first police officers to arrive at 62 Coniston Road, Ellenbrook after Ms Hebble's 000 call and they were at the scene at about 1.50am on 8 November 2008.

On their arrival the constables saw Ms Hebble sitting at the front of her home talking on the telephone. At that time Ms Hebble was speaking to an officer from Police Communications and Constable Payne spoke to her and took the telephone from her.

Senior Constable Hall entered the house and saw the bodies of Malachi and Lochlan lying on the floor of the family room, which is adjacent to the kitchen.

The area was designated a protected forensic area and was subsequently cordoned off by police using crime scene tape to contain the area.

At about 1.55am St John Ambulance paramedics arrived at the scene and spoke with police. At the request of the paramedics Constable Payne turned off the power supply to the residence at the meter box. There was a concern that there was water on the floor of the house and electrical items appeared to be touching the water.

When the residence was deemed to be safe paramedics entered the house where they saw Malachi and Lochlan lying side-by-side on the floor.

Once it was confirmed that both children were dead, the paramedics left the house.

Ms Hebble was placed in the rear of an ambulance.

At the scene St John Ambulance Paramedic Mark Lyons checked Ms Hebble's pupils, which were dilated and sluggish but reacting to light, and noted that her heart was tachycardic and her respiratory rate was fast.

At about 2.15am he took a second set of observations from Ms Hebble whose pupils were still dilated, but at that time not sluggish. At that stage she was still tachycardic but her respiratory rate was back to normal.

Medical evidence at the inquest revealed those observations would have been consistent with a high state of emotional arousal.

At about 2.30am Mr Lyons went to take a third set of observations but Ms Hebble would not let him do so and told him not to touch her.

At about 2.40am Ms Hebble was taken to Swan District Hospital by the ambulance paramedics and they arrived at the hospital at 2.58am.

At Swan District Hospital Ms Hebble refused to undergo a physical examination.

She provided a history in which she claimed that she had blacked out at the time when her children had died, but she continued to refuse an examination to determine whether there was any medical cause for her claimed blackout.

At 3.30am on 8 November 2008 Ms Hebble provided a further history to medical staff. She said that her elder child *"pooed his nappy"* and she put two of them in the shower together.

She said that she left the bathroom and went to the bedroom at which point she said that she saw *"white speckles"* in front of her eyes, felt dizzy and fainted.

This information was recorded in Emergency Department Continuation Notes of Swan District Hospital.

From the time of police first arriving at the scene until some considerable time after she was taken to Swan District Hospital Ms Hebble appears to have repeatedly stated that she wanted to die and asked *"Would somebody please kill me"* or words to that effect.

Because of her mental state Ms Hebble was transferred to Graylands Hospital where she was admitted from 8 November to 12 November 2008.

At Graylands Hospital Ms Hebble gave a history which was recorded in the Integrated Progress Notes as follows:

"I killed my babies … I passed out. I didn't do anything … I can't even remember."

The notes continued:

> Reports not visiting/going to her parents lately "I wanted to be alone", "I was shutting everyone off and pushing everyone away", "they were knocking on my door", but I told them that "I had a doctor appointment" and "I lied".

As indicated in the introduction herein, Ms Hebble did not take part in an interview with police following legal advice but provided a statement dated 11 November 2008.

In that statement she advised that her partner Mr Stevens had gone back to the mines on 3 November 2008 leaving her alone with the children.

She stated that 7 November 2008 was initially a normal day, but noted that Lochlan had been waking up during the night for about a month.

She stated that both boys had a nap after which she took them to the shower because Lochlan had pulled off a dirty nappy and had *"mushed the poo everywhere"*. [3]

The statement continued in the terms discussed earlier herein.

[3] Para 36 of statement 11 November 2008, Ex 1 Tab 26

SCENE EXAMINATIONS

A number of scene examinations were conducted by detectives and forensic officers from Forensic Field Operations, the Crime Scene Investigation Forensic Surveying Unit and the Forensic Fingerprint Bureau.

An inspection of the hot water system was conducted by Mr Matthew Ward of Rheem Australia on 11 November 2008 and he determined that the hot water system was in good working order and had no recorded faults.

On 3 December 2008 investigators obtained the assistance of Western Power investigators who examined the property to ascertain the integrity of the electricity supplied to and within the premises and to determine whether there was any possibility of an electric shock being administered by either a faulty appliance or an appliance being in contact with water.

As a result an extensive scene examination was conducted by Western Power investigators who concluded that there was no evidence of an electric shock.

On 12 November 2008 a reconstruction was performed to determine the peak water levels that could be obtained in the en suite. To facilitate the flooding of the en suite an adhesive fingerprint lifter was placed over both the shower

recess drain and the en suite drain blocking them completely. This exercise was conducted on the basis that it was possible that the drains could have been blocked at the time of the incident by objects in the shower recess or the en suite floor.

When this exercise was conducted the shower recess filled and water overflowed onto the tiled en suite floor. The water was then observed to be flowing out under the door into the master bedroom.

It was noted that the wooden floor of the master bedroom appeared to have previously sustained water damage, presumably during the original incident.

On 13 November 2008 a further test was conducted and during this examination it was discovered that the external waste pipe from the en suite floor waste drain was blocked with sand. While this would not have been relevant to draining from the shower recess itself, this blockage would have significantly or even totally prevented draining from the en suite floor.

On 14 November 2008 a further examination was conducted and on this occasion the en suite door was closed and the gap underneath the door was blocked with a towel. Once again adhesive fingerprint lifters were placed over both the shower recess drain and the en suite drain

blocking them completely. Both shower taps were then turned on, allowing the recess to fill and overflow onto the en suite floor.

Water subsequently flowed out from underneath the en suite door and into the main bedroom but the flow was significantly inhibited by the position of the towel. The depth of water level in the en suite reached a range of 49mm near the wall adjacent to the door and 55mm at the shower recess hob.

It was believed that Lochlan may have been located on the en suite floor between these two points and these tests showed that it was possible that the water level could have been sufficient to have caused him to drown lying face down, but with his face to the side, on the floor.

WHEN DID THE CHILDREN DIE?

It appears that there were no visitors to 62 Coniston Drive, Ellenbrook, in the days leading up to the deaths and Ms Hebble was the last person to see the children alive.

Evidence as to the last time a child or the children were alive came from Kristin Trappitt who lived next door at 64 Coniston Drive.

Mr Trappitt was at home during the day on Friday 7 November 2008.

Mr Trappitt believed that at some time between 1pm and 3pm on that day he was in the study at the front of his house when he heard the baby from next door (62 Coniston Drive) crying.

He said that the cry did not appear to be unusual.

According to Mr Trappitt after his wife had visited their home to obtain some documents and had left again he was in the study and noticed that the baby was crying again.

He said that the baby may have been crying at other times, but he could only remember noticing it while he was in the study.

He put the time of this cry at after 5.15pm, but before 6pm when his wife returned to the house. This was the last occasion on which he could recall hearing a cry from next door.

After 6pm he said that he and his wife spent the rest of the night at home watching the television in the theatre room.

He stated that on past occasions while watching television in the evenings he had heard the baby crying and had also heard a fan from the bathroom next door, but could not recall hearing crying or the fan on that night.

Mr Trappitt could not definitely state which of the children had been crying although he presumed that it was Malachi.

According to Mr Stevens Malachi had a particularly loud cry and could *"scream the house down".*

In the context that on the account of Ms Hebble the children must have been alone in the en suite bathroom from about 3.30pm on that day until the time of their deaths, the lack of evidence of screaming or extensive crying is surprising.

As based on the medical evidence it appears likely that Malachi collapsed and died first, it was possible that Mr Trappitt heard Lochlan crying, assuming that he heard a single cry. That would suggest that at least Lochlan was still alive at between 5.15pm and 6pm on 7 November 2008.

THE EVIDENCE OF MIRANDA HEBBLE

Ms Hebble gave evidence at the inquest and in that evidence described difficulties she experienced in coping with the young children and particularly after Malachi's birth, feeling tired all the time.

She said that she and Mr Stevens had a number of arguments about the state of the house and she had asked

her mother to help by coming over and assisting with cleaning the house. She said her mother and father would come over and help clean the house before Mr Stevens came back when he had been away working as a fly-in fly-out worker.

She gave evidence that Lochlan was a very active child and Malachi was very sleepless.

She said that she had noticed that Malachi was getting thinner at one time but claimed that he later *"... gained a bit more weight"*. [4]

She said that she could not recall the circumstances in which Malachi missed his six month required immunisation.

She said that she had changed the formula at the suggestion of a friend to assist with Malachi's feeding but did not know what formula had been suggested or whether it was the formula which was subsequently found in the house.

She said that she could not remember Malachi suffering from diarrhoea a lot and provided no real explanation as to why it was that Malachi was failing to thrive.

[4] t. 352

She later said that Malachi was not developing the same way that Lochlan had and that he did not sit up like Lochlan did at the same age and seemed generally slower in developing, but she thought that this was normal variation.

She described having rare contact with visitors apart from her own family and described contact with her parents reducing as Malachi was increasingly restless.

She had suffered from migraine headaches and said that these headaches continued after she had the children. She did not, however, suggest that migraine headaches had in some way contributed to the circumstances in which the children were ultimately left alone in the en suite.

In respect of the incident on 15 February 2008 when Malachi was left in the car at the shopping centre, she claimed, "I only remember bits of that incident, but not the whole lot". [5]

When questioned about the circumstances of the incident she continued to say that she could not remember *"much of it"*.

She was aware that the now Department for Child Protection had become involved and recalled officers of that

[5] t. 363

department knocking on the door. She said that she had not told anybody about the incident before these officers arrived at her home.

She said that she could not recall contacting the police officer later in that day and falsely telling her that she had seen a doctor.

She gave no explanation as to why she should have a particularly poor memory of the incident considering its importance but said, "I can't remember quite a bit of things that happened that year". [6] She went on to say that she was not aware of having any particular ongoing memory problems.

In respect of the incident itself and the period beforehand, she claimed that she could not recall Mr Stevens going back to work on 3 November.

In respect of the days before the incident she said in respect of her memory, *"I'm a total blank"*. [7]

She said that she could not recall the telephone conversations between Mr Stevens and herself which appear to have taken place at about 12.57pm and 3.24pm on 7 November. These calls lasted for 92 seconds and 47 seconds respectively.

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[6] t. 365
[7] t. 367

Little is known about the contents of the second telephone conversation. Mr Stevens, in his statement of 8 November 2008, made no mention of it but did refer to the earlier telephone conversation that morning in which he stated he asked Ms Hebble to contact Telstra about a billing dispute. In evidence he said that he may have called back in the afternoon to see whether Ms Hebble had followed up on his request.

It appears that there had previously been some discussion between Mr Stevens and Ms Hebble in relation to this Telstra account and it appears that she had run up a substantial bill as a result of accessing the internet. According to Mr Stevens the Telstra charge was for about $1,500 while according to Ms Hebble it was for about $10,000.

This telephone conversation was significant as it appears to have taken place shortly before the children were put into the en suite shower and it appeared at least possible that there could have been a distressing element to the call as far as Ms Hebble was concerned.

The following exchange took place with Ms Hebble about the period after Mr Stevens left to go to work on 3 November 2008:

> And then there was a number of days before the incident happened?---I'm, a total blank.
>
> You're saying you can't remember anything about that?---I cannot.
>
> You don't recall the telephone call on the day?---No, I do not.
>
> You're saying you don't remember anything at all about the whole week?---About the whole week, it's all gone. [8]

Ms Hebble stated that she could not recall taking the children to the bathroom and could not recall whether she had anything in the shower recess for the baby to rest his head on so that his head would not be on the hard tiles.

Later in her evidence Ms Hebble gave the following account in respect of her recollection:

> Are you telling me you can't remember anything at all about this day?---I can remember seeing sparkles.
>
> What was happening then?---I went to get something out of the master bedroom - - -
>
> Where were the children?---In the shower.
>
> So do you remember the children in the shower?---Yes.
>
> Do you remember putting them in the shower?---I can't remember what time or anything like that, but I did put the children in the shower.
>
> Do you remember doing that?---Yes, to some - - -
>
> Do you remember why you put them in the shower?---I had a routine. I'd put them in the shower. If they had dirty nappies or before bed or after they got out of bed in the morning.

[8] t. 367

On this occasion do you remember why you put them in the shower?---No, I do not.

So you do remember putting them in the shower?---Yes. I remember putting them in the shower, but I don't know why. [9]

Ms Hebble's account in respect of the incident was continued in the following exchange:

So you had the two children in the shower. Were you in the shower?---No, I was not.

Where were you?---I was at the side of the shower.

Do you remember what you were wearing?---A dressing gown.

A dressing gown? What happened then?---I showered them. I went to get something and then sparkles.

And what did you go to get?---I do not know.

Where did you go to get it?---From one side of the bed.

What bed?---The master bed.

All right. So you went to get something from a side of the master bed?---Yes.

Which side of the master bed?---It would be my side because that's where we kept all the baby stuff sometimes.

I see. Is that the furthest away part of the bed?---Yes.

And then what happened?---I saw sparkles. I can't remember anything after that.

What were you doing when you saw the sparkles?---Reaching for something.

Where were you?---On my side of the bed. [10]

[9] t. 370-371
[10] t. 371-372

When asked whether she had seen these sparkles before, Ms Hebble stated that she had, when she moved too quickly or when she was tired and fatigued.

She said that she continued to see these sparkles after the event and that usually when she saw the sparkles she would reach out to hold something to stop herself from being dizzy. She said that usually that was all that happened.

Ms Hebble claimed that she could not recall refusing a physical examination at Swan District Hospital and when asked why she might have refused such an examination she suggested that she may have been distressed.

She stated that she could not recall wanting to find out what might have been wrong with her to explain the long period of her apparent lack of consciousness while the children were in the en suite.

Ms Hebble stated that when she woke up there was water on the floor coming from under the door and there was a light on in the bathroom. She said that she did not turn the light on when she went to the bathroom.

She described finding the children with Malachi in the shower and Lochlan on the en suite floor.

In respect to the light being on in the bathroom, it is difficult to understand how the light could have been on if the children were left in the en suite at about 3.30pm, when it was daylight, and Ms Hebble was then unconscious or asleep.

Ms HEBBLE'S CLAIMED AMNESIA

Ms Hebble's claimed loss of memory is too extensive to be explained by ordinary forgetfulness and it relates to information which would not be likely to be forgotten because of lack of importance or for any other reason. The extent of claimed memory loss is such that it can be categorised as a claim of amnesia.

While Ms Hebble was undoubtedly extremely distressed by the events, that of itself would not explain such an extensive loss of memory. In this context it is noted that the claimed memory loss does not only relate to memories of an apparently traumatic or stressful nature. Interestingly, Ms Hebble could recall seeing the children in the shower, discovering and moving their bodies and other traumatic events, but claimed lack of recall of the events of the week, her partner's telephone call on the day of the incident and other relatively non-traumatic incidents and events.

It is also significant to note that Ms Hebble could recall events of the week before the incident at least for days after

it. In her statement dated 14 November 2008 she described a recollection of a number of events during the course of that week and made no suggestion of "a total blank".

It is also relevant to note that Ms Hebble's claimed amnesia also applies to the incident of 15 February 2008 and again in relation to that incident she did not claim any significant memory loss or memory gaps when she spoke to her partner or representatives of the now Department for Child Protection.

In the above context I do not accept that Ms Hebble at the time of giving evidence at the inquest did suffer the extent of memory loss which she claimed. In my view it is far more likely that the claimed amnesia was a defence mechanism to avoid confronting difficult facts or was simply made up to avoid answering difficult and unpleasant questions. Whatever the reason for the claimed forgetfulness, in the absence of evidence as to many of these events it was impossible at the inquest to reach definitive conclusions in relation to a number of matters bearing on the circumstances of the deaths.

MS HEBBLE'S CLAIM THAT SHE WAS EITHER ASLEEP OR UNCONSCIOUS FOR ABOUT 10 HOURS WHILE HER CHILDREN WERE IN THE EN SUITE

According to Ms Hebble's accounts she must have fallen asleep or lost consciousness not long after 3.24pm

(the time of the last call from Mr Stevens) and did not wake up until not long before 1.32am (the time of the 000 call), a period of approximately ten hours.

Ms Hebble's medical records were reviewed for the purposes of the inquest by medical practitioners and there appeared to be no medical explanation for such a long period of unconsciousness.

Clinical Professor Graeme Hankey, consultant neurologist with the Stroke Unit of the Department of Neurology, Royal Perth Hospital, provided expert evidence in relation to medical records relating to Ms Hebble both before and after the incident.

Professor Hankey concluded that Ms Hebble had no history of any neurological disorders other than migraine. Notably, there was no past history of epilepsy, subarachnoid haemorrhage, psychiatric disease, substance abuse, hypertension, heart disease, diabetes, liver disease, kidney disease, adrenal disease, or thyroid disease, and she was apparently taking no relevant medications.

There was nothing about Ms Hebble's health generally which would cause recurrent episodes of loss of consciousness, although it was noted that she had reported having passed out on two previous occasions (these reports were said to relate to much shorter incidents). The details

and circumstances of the two events are effectively unknown.

Professor Hankey noted that Ms Hebble had undergone a brain scan and that there was no structural abnormality to her brain. She had no history of ongoing visual disturbances.

In respect of Ms Hebble's claims that she had *"passed out"* Professor Hankey explained that this is a colloquial term whereas *"losing consciousness"* has a specific meaning, that the person cannot be readily aroused.

In respect of any possibility that Ms Hebble might have simply fainted, he explained that any loss of consciousness as a result of fainting would be likely to be very brief. He said that the cause of fainting is a lack of blood flow to the brain which is usually very transient and that in the event that the person who has fainted is then lying down, the blood flow would be expected to return to the brain causing that person to wake up.

Mr Stevens gave evidence to the inquest that on occasions Ms Hebble had slept, or appeared to sleep, very deeply and had even slept through the screaming of her own child in the next room. Professor Hankey observed that this evidence suggested that Ms Hebble could get very tired and could sleep for a long time and be unaware and

unresponsive. This would, however, be sleep and ultimately she would be rousable with sufficient stimulation.

In the above context, Dr Winterton gave evidence that it is unusual for a mother to sleep through the screaming of her own baby. Dr Winterton observed that it is *"amazing"* how mothers are very tuned to their own child's crying. He said that even in a children's hospital when a baby is in a cot in an adjacent room from the mother and there are a number of babies crying, a mother can identify her own child's cry.

CONCLUSION

Malachi Stevens and Lochlan Stevens both died on the evening of 7-8 November 2008. They appear to have died in the en suite bathroom adjacent to the master bedroom at 62 Coniston Drive, Ellenbrook.

According to their mother, Ms Hebble, the children must have been in the en suite for a period of approximately ten hours while she was either asleep or unconscious in the adjoining bedroom.

There was no medical explanation for Ms Hebble being unconscious for such a long period of time and if her account was truthful, it appears most likely that she must have simply been in an extremely deep sleep.

Why Ms Hebble was not roused by noises or cries from the children in the en suite is not known.

On 15 February 2008 Ms Hebble had left Malachi Stevens unattended in a car at Woodlake Shopping Centre in circumstances where the airconditioning was not running and he could easily have died as a result.

There is a significant body of evidence which indicated that prior to the deaths Ms Hebble was increasingly suffering a deterioration of her level of functioning. She had, for example, been unable to keep the house clean and had found it necessary to seek assistance from her parents to clean the house prior to the arrival of her partner when he returned from work at his fly-in fly-out employment.

In addition Ms Hebble was becoming increasingly socially isolated and it appears likely that she had no direct contact with any other adult in the days before the deaths.

Even assuming Ms Hebble's account is accurate, to have placed a ten month old baby and a two year old child in a shower recess with the shower running and to have gone elsewhere was a high risk action.

It appears certain that at some stage the en suite shower recess and the en suite itself was flooded with water from the shower and this water ran under the door and

through the house. The possibility that both children drowned cannot be excluded.

It is likely that Malachi died first as lividity on his body appeared more settled and there was evidence of green colouration to his stomach indicative of early decomposition.

In the period leading up to his death Malachi had been failing to thrive, and his health had been deteriorating. For a significant period his condition was such that medical intervention and probably hospitalisation was required.

Unfortunately his deteriorating condition did not seem to be appreciated by Ms Hebble and even Mr Stevens and he was not taken to see a doctor.

In the case of Lochlan Stevens it appears likely that his death took place over a significant period of time. In respect of how it was that he came to collapse onto the bathroom floor, it is significant that he appeared to be suffering from early pneumonia with acetone in the blood and urine. Neuropathological findings indicated that he had suffered either a mild concussive head injury and/or a metabolic condition resulting from low blood sugar. These findings together were consistent with prolonged or delayed death over some time (hours) and would be consistent with exhaustion, hunger and possibly hypothermia contributing

to death. Once he had collapsed, there may have been a possible contribution by drowning dependant on the level of water in the bathroom, but this is unable to be confirmed.

Prior to these events there was not any obvious physical reason identified which could explain why Lochlan would not have been able to scream for help. He was a robust child who was previously in relatively good health.

Some cries at least were heard next door up until about 5.15pm – 6pm that night and it appears likely that at least Lochlan would have made a significant noise in the en suite in the hours leading up to his death. Why this noise did not rouse Ms Hebble if she was asleep in the adjoining master bedroom has not been explained.

In respect of both children no food material was located within their stomachs and it is difficult to comment on when they were last fed.

Based on the account of Ms Hebble, assuming that is accurate, neither child had been fed for a period of at least ten hours prior to death.

There are a considerable number of features of this case which are unexplained and may never be known. This was a very unusual case. For two children to die within hours of each other in somewhat different circumstances

appears to be a remarkable turn of events. In addition the claim that the mother of the children was asleep or unconscious in the next room for a period of ten hours while they remained in an en suite bathroom where the shower was left on is very unusual.

Clearly the children did not die from natural causes, but the circumstances in which they died have not been revealed by the evidence at the inquest.

I make an Open Finding as to how the deaths arose.

COMMENTS IN RELATION TO PUBLIC HEALTH AND SAFETY ISSUES

While the circumstances in which the deceased boys died are to a large extent unknown and it is difficult to reach conclusions as to contributing factors, it is obvious from the whole of the evidence that a significant factor must have been Ms Hebble's obvious inability to cope with the difficult situation in which she found herself and her failure to think clearly and to ensure that the children were not put at risk.

In that context an obvious question was whether Ms Hebble suffered from post-natal depression or from some other form of anxiety or mental illness.

At the inquest helpful evidence was provided by Dr Felice Watt, Head of Department and Consultant

Psychiatrist with the Women and Newborn Health Service of King Edward Memorial Hospital.

Dr Watt provided a comprehensive letter responding to questions asked by counsel assisting and expanded on those answers at the inquest.

Dr Watt defined post-natal depression as depression experienced in the first twelve months post partum. She stated that this depression is frequently accompanied by anxiety and as some symptoms characteristic of depression include symptoms which may be experienced by most women in the post-natal period (eg tiredness and sleep disturbance) this makes the diagnosis of post-natal depression difficult to make.

In Ms Hebble's case Dr Watt gave particular weight to the psychiatric assessments made soon after the deaths of the children at Swan Health Service Emergency Department and Graylands Hospital. Importantly the inpatient assessment at Graylands Hospital afforded the opportunity for Ms Hebble to be assessed on a number of occasions and included close observation by nursing staff over the period from 8 November 2008 until 12 November 2008.

The Graylands Hospital Discharge Summary indicated that the Consultant Psychiatrist's assessment was of a final diagnosis of *"acute stress reaction"*. It was commented that

"Ms Hebble did not display any significant depressive symptoms during this hospitalisation".

It was, however, clear that Ms Hebble did suffer from a number of symptoms which may be indicative of depression.

These included possible weight loss and loss of appetite, insomnia or sleeplessness over extended periods prior to the death of the children reported by Ms Hebble and expanded on in her evidence, reduced energy, social withdrawal and possible anxiety symptoms.

There was significant evidentiary material provided to the inquested which suggested that Ms Hebble was experiencing periods of impaired functioning, such as the evidence relating to the incident of 15 February 2008 and evidence to the effect that she was not able to keep the house clean and had sought assistance from her parents.

Dr Watt made the following observation in relation to her assessment of the available evidence in her letter to counsel assisting:

> Diagnosis aside, it is clear that Ms Hebble was struggling with the demands of looking after two young children. She was tired, anxious at times, and frequently was without the support of her partner (a fly-in fly-out worker) and somewhat socially isolated. There may have been financial and relationship stress and difficulty managing her oldest child's behaviour. At times this appears to have impacted on her capacity to care adequately for the children, however in the main she is reported as being a loving and responsive mother. The extent to which these factors were causally related to the children's death is unclear.

In the above context Dr Watt was asked about what was being done to promote awareness about these issues to which she responded by stating that all Australian states and territories, along with beyondblue, have been involved with the National Perinatal Depression Initiative. She advised that this initiative has provided funding for increased activity in the key areas of community awareness raising, routine universal screening, treatment, care and follow-up support in addition to workforce development and training. She stated, however, that she is concerned to note that there are issues in relation to ongoing funding for this initiative and made the observation that cessation of this funding may result in failure to sustain an increase in progress that has been made and could potentially result in delayed notification and treatment for women at risk of or experiencing post-natal depression.

While the National Perinatal Depression Initiative was not the subject of critical review during the course of the inquest and it would not be appropriate for me to make any recommendations in relation to that initiative herein, it is clear that there is a need for ongoing community awareness raising and where necessary treatment, care and follow-up support for women who find themselves overwhelmed by anxiety or depression while endeavouring to look after small children.

This case has highlighted the need for there to be ongoing community awareness of this issue and the importance of there being adequate support mechanisms in cases where the demands of coping with young children, often in relatively socially isolating circumstances, can set off an escalating cycle of distress for mothers and give rise to unacceptable threats to child safety.

A N HOPE
STATE CORONER
11 June 2013