CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Cheyse Williams-Empson**
Citation:	**[2019] ACTCD 9**
Hearing Dates:	29-31 May 2019; 3-4 June 2019
Decision Date:	31 July 2019
Before:	**Chief Coroner Walker**
Decision:	See [26], [31]
Catchwords:	**CORONIAL LAW** – cause and manner of death – death of baby aged 3 months – use of illicit drugs by mother – appropriateness of response by Child and Youth Protection Services
Legislation Cited:	*Coroners Act 1997* (ACT)
Cases Cited:	*Briginshaw v Briginshaw* (1938) 60 CLR 336 *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 (5 August 2005) *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506 *Harmsworth v The State Coroner* [1989] VR 989
Parties:	Counsel Assisting the Coroner Amanda Williams Karinya House The Australian Capital Territory
Representation:	**Counsel** Ms Sarah Baker-Goldsmith (Counsel Assisting) Dr Gregor Urbas (Amanda Williams) Mr John Purnell SC (Karinya House) Ms Katrina Musgrove (The Australian Capital Territory) **Solicitors** Legal Aid ACT (Amanda Williams) Sparke Helmore (Karinya House) ACT Government Solicitor (The Australian Capital Territory)
File Number:	CD 144 of 2017

CHIEF CORONER WALKER:

1. Cheyse Williams-Empson, born 7 March 2017, died on 25 June 2017 aged 3 months and 18 days. An inquest was held to determine the manner and cause of his death,

that death having been referred to the Coroner pursuant to section 13(1)(a) of the *Coroners Act 1997* which provided relevantly, at that time, that a coroner must hold an inquest into the manner and cause of death of a person who dies unnaturally in unknown circumstances.

General Background

1. Coronial proceedings are civil proceedings and so the civil standard of proof, the balance of probabilities, applies in coronial matters. In assessing the evidence in this inquest, I have regard to the principle laid down in in *Briginshaw v Briginshaw* (1938) 60 CLR 336:

> The truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found... The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal.

2. At the time of his death, Cheyse was living in a cottage at Karinya House ('Karinya') with his mother, Ms Amanda Williams. Karinya is a community organisation which provides accommodation, transitional housing and outreach services to pregnant and new mothers in need of specialised support.

3. At about 5:30am on 25 June 2017, Cheyse woke up. He was breastfed and bottle-fed with formula then placed back in his bassinet by his mother. A blanket was placed over him and a face washer underneath his head. At about 7:00am, Ms Williams fell asleep on the lounge watching television. At about 11:00am, Ms Kimberley Castles, a staff member at Karinya, went to Ms William's cottage to conduct a routine welfare check. Ms Williams appeared to have just woken up and told Ms Castles about feeding Cheyse earlier that morning. After Ms Castles left, Ms Williams went inside the cottage and found Cheyse unresponsive in his bassinet. His blanket was covering his mouth and half of his face. She immediately called out for assistance. Ms Castles re-attended the cottage and commenced cardio-pulmonary resuscitation while Ms Williams called 000. ACT Ambulance Service officers attended shortly thereafter. They determined on arrival that Cheyse was deceased. Police also attended.

4. Ms Williams had a history of illicit substance use, particularly heroin. This had, in part, resulted in her other children being removed by Child and Youth Protection Services ('CYPS'). During her pregnancy and after Cheyse's birth, she was on the methadone programme with her dose increasing towards the end of her pregnancy. Prior to discovering she was pregnant, Ms Williams was injecting heroin daily. When she discovered she was pregnant with Cheyse, she reduced her use to a 'couple times a week'. She maintained this dosage for a period of time and then reduced her usage further as the pregnancy progressed.

5. In light of action taken by CYPS with regard to her previous children, Ms Williams sought the assistance of Karinya during her pregnancy to provide support on Cheyse's birth. She also voluntarily agreed to notify CYPS of her pregnancy and submit to urinalysis as part of a CYPS Safety Plan. The urinalysis was also a precondition of her admission to Karinya. She was accepted into Karinya's residential program and commenced living there on 10 March 2017.

6. Cheyse's birth was unremarkable. However, due to his mother's use of methadone and heroin during pregnancy, he was born with neo-natal abstinence syndrome. At three days old, Cheyse displayed acute withdrawal symptoms and morphine treatment was commenced. His condition improved with treatment. He was discharged from The Canberra Hospital on 28 March 2018 and joined Ms Williams at Karinya that day.

7. In terms of ongoing medical care Cheyse was discharged to the Blue Star Clinic, where he saw Dr Felicity Williams. Dr Williams initially saw Cheyse weekly but, after Cheyse no longer needed morphine treatment, she saw him less frequently. She described Cheyse as 'growing and developing well'. She never held any concerns in respect either of Cheyse or the way he was being cared for by Ms Williams.

8. Cheyse was regularly reviewed by a Maternal and Child Health ('MACH') Nurse, Ms Laurel King, who attended at Karinya on three occasions between March and June 2017. Ms King saw nothing in her interactions with Ms Williams or her examinations of Cheyse which caused her any concern. She thought Cheyse was doing well.

9. CYPS established a Declared Care Team under section 862 of *the Children and Young Persons Act 2008* in respect of Cheyse's involvement with that agency. The purpose of a Declared Care Team is to allow CYPS information to be shared with other persons involved with the care of a child in whom CYPS have an interest to 'work with collaborative practice'. Cheyse's CYPS case worker, Ms Soja Mathew, was the Declared Care Team Coordinator. Two of Ms Williams' Karinya House case workers, Ms Catherine O'Halloran and Mrs Catherine Cooney, were members of the Declared Care Team. Dr Williams in the Blue Star Clinic was not a member of the Declared Care Team. However, Dr Williams would copy her correspondence about Cheyse to CYPS to keep them informed and to be used as needed. Ms King also was not a member of the Declared Care Team.

10. Ms Williams used heroin within a week and a half of Cheyse's birth and continued to regularly use, on average a few times a week and usually in the afternoons. She started to cut down, going four or five days between using heroin, and using smaller amounts. While most of the time Ms Williams used heroin away from Karinya, on a few occasions she used heroin whilst living in the main house there. She agreed that given her long history and experience of heroin use, it could be difficult for observers to detect that she was under the influence of heroin when she had only used small amounts. Ms Williams said she last used heroin five days prior to Cheyse's death. A urinalysis sample provided on 22 June 2017 tested positive, although that result was not available to CYPS until after Cheyse died.

11. Ms Williams had disclosed her prior heroin use to Karinya, CYPS, MACH and the Blue Star Clinic. In an assessment form for Karinya, she disclosed that she had used heroin as recently as September 2016 in the early stages of her pregnancy. However, none of these services knew that Ms Williams had continued to use heroin throughout rest of her pregnancy and after Cheyse was born. Ms Williams actively took steps to hide her heroin use and to prevent these services becoming aware of her ongoing heroin use. These included:

    (a) failing to attend appointments for urinalysis on 14 occasions between 16 February 2017 and 13 June 2017 inclusive (although allegedly some of the missed appointments were for legitimate reasons such as running late);

(b) providing samples of urine that was not hers at appointments for urinalysis (sometimes referred to in testimony as 'false urine') on 15 occasions between 26 April 2017 and 15 June 2017 inclusive;

(c) being dishonest with Karinya staff members who queried her about irregularities in her urinalysis results, including on 10 April and 2 June 2017, and her presentation when returning to the facility after an agreed curfew time on one of a number of occasions that she returned late; and

(d) after Cheyse died, reporting only methadone use in answer to police questions about whether she was on any medication or illicit drugs.

12. There were in fact a number of indicators which, when looked at retrospectively and as a whole, give a good indication that Ms Williams was still using heroin whilst living with Cheyse at Karinya. The absence of methadone metabolites in a number of samples given by Ms Williams whilst she was on methadone and the positive presence of heroin metabolites in a later sample, which ultimately came to light after Cheyse's death. As CYPS accepted in its submissions, the systems in place for communication regarding Ms Williams' urinalysis results were 'not of the requisite standard'. These were neither accessed by CYPS staff nor communicated to the relevant case worker and Declared Care Team members in a timely manner. Ms Matthews, the CYPS case worker, was suspicious as to what the available urinalysis results disclosed but was in the process of accessing expert advice about this. Possibly, a more comprehensive review of factors relating to Ms Williams, as they were known to various people within the Declared Care Team, particularly CYPS and Karinya staff, along with a more robust challenge to her claim to be abstinent, may have exposed her ongoing heroin use earlier.

13. Ms Williams regularly breastfed Cheyse. She was encouraged by staff at the hospital after Cheyse's birth to breast feed if she could; she was advised that the methadone in her system would assist Cheyse to get through his neonatal abstinence syndrome. She was also encouraged to breastfeed by staff at Karinya, Dr Williams in the Blue Star Clinic and her case worker. This was consistent with hospital policy which reflects what is understood to be current best practice taking in to account the broader benefits of breastfeeding. Ms Williams struggled to produce sufficient quantities of breast milk though and, from shortly after his birth, Cheyse was primarily receiving his nutrition from bottle-feeding with formula. Ms Williams was continuing to put Cheyse on the breast mainly for his comfort.

14. Ms Williams was never specifically advised by any of her support team of the risks of using heroin while breastfeeding, however, Ms Williams clearly perceived there to be some risk in this as she said that she would not breastfeed Cheyse immediately after having used heroin. It was also contrary to Karinya's policy to the extent that, if found to be still using, she would be in breach of her contract with the facility and likely would have been expelled. She was aware of this.

15. Ms King, the MACH nurse, last saw Cheyse on 22 June 2017. She described Cheyse's presentation as 'generally healthy' and found nothing that she considered problematic or worrying. She noted that there was nothing to suggest that he was suffering from opioid withdrawal. Karinya also maintain that, from their perspective, Ms Williams was a loving and caring mother. They submit that Cheyse was healthy and was meeting all of his milestones. The Territory, on behalf of CYPS, agree with this assessment of Cheyse's development in that he was well nourished and meeting

his milestones. Nothing discovered at post-mortem examination contradicts this assessment.

Cause and Manner of Death

16. The pathologist who conducted the post-mortem examination of Cheyse, Professor Johan Duflou, was unable to determine a medical cause for Cheyse's death. In oral evidence, he stated that ostensibly Cheyse's death had all the appearances of a Sudden Infant Death Syndrome ('SIDS') death but, because of evidence of drug exposure and the death of a half-sibling, Cheyse's death could not be categorised as SIDS. He considered that other causes of death such as seizures, cardiac arrhythmias (such as long QT syndrome) or metabolic disturbances were unlikely given the lack of any positive indication of such conditions. Professor Duflou opined that the positive post-mortem bacteriology result was most likely contamination and there was no other evidence of significant bacterial or viral infection present. He opined that fluid in and around Cheyse's nose and mouth most likely emerged after his death given the lack of presence of any inflammatory cell reaction. He expressly ruled out aspiration as a possible cause of death. Professor Duflou said that the fatty infiltration of Cheyse's liver was most likely a normal presentation and was not pathological.

17. While detail as to Ms Williams' ongoing use of heroin was not available at the time he wrote his report, upon being advised, Professor Duflou indicated that that information did not change his opinion as to Cheyse's death. Professor Duflou stated that the information in relation to the position of the blanket over Cheyse's mouth raised the possibility of 'a suboptimal sleeping environment' and a sleeping accident, but he did not put the matter any higher than a 'slight possibility'. He agreed that there was no indication that heroin was a cause of Cheyse's death or that neonatal abstinence syndrome contributed to or caused Cheyse's death.

18. Professor Duflou was cross-examined by Ms Williams's legal representative in relation to the SIDS San Diego criteria. He agreed there was variation among forensic pathologists as to the approach to sudden infant death classification. However, Professor Duflou maintained his original opinion. It was not put to him directly that Cheyse's death should be classified as a SIDS death or that the San Diego criteria were defective.

19. Dr Sarah Parsons, a specialist forensic pathologist with expertise in children, also provided a report for the assistance of the Coroner. Dr Parsons agreed with Professor Duflou's opinion as to Cheyse's cause of death, and specifically agreed that evidence of heroin and methadone exposure, as well as the death of a half-sibling, meant that a SIDS was not an available explanation. Dr Parsons also agreed that Cheyse's exposure to heroin had not caused his death but was suggestive of a child at risk. Dr Parsons also analysed a hair sample that was taken from Cheyse at the post-mortem examination. There was evidence in it of exposure to heroin. She was unable to say when Cheyse had been exposed to heroin, or whether the exposure was through maternal breast milk. Dr Parsons noted that:

> Current literature and advice on breast feeding and methadone is that the benefits of methadone maintenance treatment for both the mother and baby outweigh any risks from … neonatal withdrawal syndrome' but that '[u]se of illicit drugs such as heroin can cause problems ... due to the fact that exact composition of the drug is not known'.

20. Dr Parsons deferred to the expertise of her colleague, Dr Dimitri Gerostamoulos, an expert forensic toxicologist, in relation to questions about exposure through maternal breast milk, toxic and lethal levels of heroin for infants, heroin metabolism post-mortem and persistence of heroin in breast milk. Dr Gerostamoulos gave oral evidence at the hearing in which he said that the test results on Cheyse's hair indicated that he had been exposed to or consumed heroin and methadone:

> either prior to being born or after birth in the form of administration through breastmilk or exposed to these drugs in the environment that the child was in.

He said that it was unlikely that this exposure could be the result of being around someone who had smoked heroin, but it could not be ruled out. The most likely explanation was:

> The actual consumption or exposure to this drug from the mother … either in utero or post birth, in which case … [it was] delivered through breast milk.

Dr Gerostamoulos was unable to say whether Cheyse was exposed to the substances was via breast milk or in utero; it could have been a combination of both. He said there was no evidence of recent or acute toxicity to heroin or other drugs, and no direct evidence that heroin caused Cheyse's death. However, he noted in a written comment for Dr Parsons's report that:

> Children under 2 years of age do not have the capacity to metabolise drugs to the same extent as adults and therefore drugs may persist in the body for longer periods of time.

21. Cheyse's in utero exposure to heroin undoubtedly contributed to his developing of neonatal abstinence syndrome. However, that risk existed in any case due to Ms Williams' receiving methadone maintenance treatment while pregnant and breastfeeding. Dr Williams' evidence was that babies that are on methadone are more likely to suffer from neonatal abstinence syndrome than babies that have only been exposed to heroin. There is no evidence that Cheyse was exposed to heroin at any time at a level likely to produce a fatal overdose response.

22. Dr Parsons noted that a seizure leading to Cheyse's death, possibly from withdrawal, could not be entirely excluded. This observation was made at a point in time at which Ms Williams' continued use of heroin after Cheyse's birth was not known. However, the evidence of Professor Duflou was that a seizure-related death was unlikely in circumstances where Cheyse had no history of seizures. Dr Carlisle, the Clinical Director of Neonatalogy at The Canberra Hospital, noted that a seizure from opioid withdrawal is very rare and she had never seen one in ten years of practice at The Canberra Hospital. The evidence of both Ms King and Dr Williams was that Cheyse had no history of seizures. Dr Carlisle also gave evidence that withdrawal symptoms were more related to a chronic dependency rather than an acute exposure, and that an infant in such circumstances would be very unlikely to have a seizure without having other symptoms. If Cheyse suffered from opioid withdrawal at a severity sufficient to cause his death on 25 June 2017, it is highly improbable that he would have displayed absolutely no symptomology of withdrawal prior to his death. Opioid withdrawal should be rejected as a possible cause of Cheyse's death.

23. There is a theoretical possibility that Cheyse died as a result of a sleeping accident given the evidence as to him being discovered with a blanket over his nose and mouth. However, there is no evidence that Ms Williams put Cheyse to bed on the morning of 25 June 2017 with the blanket over his mouth and her evidence was explicitly to the contrary. The advice Ms King gave to Ms Williams a few days earlier

was that Cheyse no longer needed to be wrapped for sleeping. In all probability, given Ms Williams' belief that the blanket was not tucked in, there was sufficient free movement of the blanket to create the position in which Cheyse was discovered. It was Ms Williams's opinion that the blanket over Cheyse's mouth and nose would not have prevented his breathing. Ms King's professional opinion was that Cheyse had sufficient muscle strength to be able to naturally move into a position should a blanket have impeded his breathing. Accordingly, the possibility of a sleeping accident causing Cheyse's death should be discounted.

24. It is impossible to deduce what, if any, contribution Cheyse's exposure to heroin or methadone via his mother had to his death. There is no evidence that Cheyse died as a direct result of the actions of another person. Consequently, in this factual scenario, there is no evidence that Cheyse died as a result of the inaction of another.

25. I am required by section 52(1) of the *Coroners Act 1997* to make findings as to the identity of the deceased person, when and where they died and the manner and cause of their death. On the evidence before me, however, I am unable to find the manner or cause of Cheyse's death.

26. I make the following formal findings:

    (a) the deceased, Cheyse Williams-Empson, died at Karinya House in the Australian Capital Territory on 25 June 2017. The address of Karinya House is not to be published pursuant to enduring court order;

    (b) the manner and cause of his death is unascertained.

Matters of Public Safety

27. I am required by section 52(4)(a) of the *Coroners Act 1997* to state whether a matter of public safety is found to arise in connection with the inquest and, if I find such a matter, I may comment upon it.

28. I remind myself of the guidance given by the Full Court of the Supreme Court in *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 (5 August 2005) that:

> The task of a coroner is not to determine whether anyone is entitled to some legal remedy, is liable to another or is guilty of an offence. The Coroner's task is to inquire into the matters specified in the relevant section of the *Coroners Act 1997* and make, if possible, the required findings and any comments that may be appropriate...
>
> ... It does not provide a general mechanism for an open ended inquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to the circumstances in which the death or fire occurred.

29. I remind myself of the scope of a Coroner's power to comment as discussed by Nathan J in *Harmsworth v The State Coroner* [1989] VR 989 at 997:

> The power to comment arises as a consequence of the obligation to make findings… It is not free ranging. It must be comment 'on any matter connected with the death.' The powers to comment and also to make recommendations… are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner's prime function that is to make 'findings.'

30. There were a number issues properly canvassed at the hearing which included: the ingestion of heroin by Cheyse in utero and through breast milk, concerns over the urinalysis monitoring by CYPS and a failure to detect Ms William's ongoing heroin use, the positioning of the blanket on Cheyse in the bassinet and, ultimately, the appropriateness of the responses by the various services involved in Cheyse's care. CYPS and Karinya were reflective of their roles and, where appropriate in submissions, have indicated an intention to review relevant practices.

31. However, in light of my findings that none of these factors can be causally linked to Cheyse's death, pursuant to section 52(4)(a)(i) of the *Coroners Act 1997*, I cannot find that a matter of public safety is found to arise in connection with this inquest.

32. I decline to make any further comment or recommendations.

33. I extend my deep condolences to Cheyse's family and those involved in his care.

I certify that the preceding 33 numbered paragraphs are a true copy of the Findings of her Honour Chief Coroner Walker.

Associate: R. Boughton

Date: 31 July 2019