CITATION: *Inquest into the death of Ruby Blitner* [2017] NTLC 021

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Katherine
FILE NO(s):	D0118/2016
DELIVERED ON:	10 August 2017
DELIVERED AT:	Darwin
HEARING DATE(s):	18 July 2017
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in care, natural causes, appropriate care, timeliness of police investigation, Territory Families compliance with request for files**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Police:	Bill Rogers
Counsel for Territory Families:	Gabby Brown

Judgment category classification:	A
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IN THE CORONERS COURT
AT KATHERINE IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0118/2016

In the matter of an Inquest into the death of

RUBY BLITNER
ON 26 JULY 2016
AT KATHERINE DISTRICT HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Ruby Blitner (the deceased) was born on 28 March 2009 to Courtney Chunama (of Kununurra) and Daniel Blitner (of Rockhole Community) at the Royal Darwin Hospital.

2. Ruby had one older brother. Her father remembers her in the first two years as being very energetic. He said she ran everywhere.

3. The family moved to her mother's country at Mud Springs. On 7 May 2011 when she was just two years and three months old she was noticed to have a high fever. She was taken to the Kununurra District Hospital that day and the following day. It was noted that she was suffering altered levels of consciousness and focal seizures.

4. She was evacuated to Royal Darwin Hospital on 9 May 2011. She was intubated in ICU while diagnostic tests were performed. She was diagnosed with Murray Valley Encephalitis. It was thought that she was bitten by a mosquito on a fishing trip the previous month.

5. She was successfully extubated on 21 May 2011 and admitted to the paediatric ward. However, the Murray Valley Encephalitis left her with an acquired brain injury resulting in spastic quadriplegic cerebral palsy. Under

the Gross Motor Function Classification System (GMFCS) her cerebral palsy was classified at level 5 (the highest level of dysfunction).

6. She could not talk, or support her weight in any position. She was fully dependent and had a poor gag reflex and so was fed through nasogastric tubes. A percutaneous endoscopic gastrostomy (PEG) was inserted on 21 February 2012, in Adelaide.

7. She also had epilepsy and frequently suffered from recurrent aspiration pneumonia. She developed thoracolumbar scoliosis (curvature of the spine) that became progressively worse and affected her ability to breathe (restrictive lung disease).

8. The prognosis at the time was expressed as follows:

> "Ruby has suffered severe, irreversible brain damage. Her functional status is unlikely to improve, despite being medically stable and Murray Valley encephalitis being a non-progressive condition. Ruby is at high risk of mortality associated with aspiration of secretions, or seizures, and hence has been accepted under the palliative care service.

9. A "not for resuscitation" order was signed and verified with her parents. The limitation was for airway support with bagging for up to 10 minutes, no intubation and no injections or blood tests.

10. Her parents separated in May 2012 and her mother took her back to Mud Springs where she had more family for support. Ruby got sick and was admitted to Kununurra District Hospital. Due to the poor environment in Mud Springs her family was provided a house in Kununurra. However, because of her high needs and the lack of respite and support services in Kununurra she spent a large proportion of her time in the hospital.

11. On 3 August 2012 the newspaper, *The West Australian*, ran a story on Ruby and the difficulties her mother had managing in Kununurra (due to the lack

of support and services). A group of supporters had set up a fundraising project for her titled “Jewel of the Kimberley”.

12. In October 2012 and March 2013 she had two orthopaedic procedures on her hips at the Princess Margaret Hospital for Children in Perth. The first involved releasing muscles and nerves that were contracting. After that surgery she was in full lower body plaster for 7 weeks. The second procedure involved cutting both femoral thigh bones and repositioning the balls of the femurs and refixing them to the femurs with metal plates. It was a necessary procedure due to the spasticity pulling the ball out of the joint. She wore a Rhino brace for 12 weeks following that surgery.

13. On 6 July 2013 her mother took her back to Katherine to find more sustainable support and care options.

14. During an admission to Royal Darwin Hospital the paediatrician expressed the opinion that Ruby had, “very high care needs, which would be difficult for any family to manage”.

15. Eventually the Department of Children and Families took over her full time care. A Temporary Placement Arrangement was entered into on 9 September 2013 and a formal order for care until the age of 18 years was made by the Court on 4 March 2014.

16. Ruby’s parents were happy with the care that Ruby had while in care. They also appreciated the efforts the Department of Children and Families to ensure they were able to see Ruby whenever they wished and when from time to time she fell ill.

17. Her mother recounted:

> “She used to always get chest infections. She was sick a lot with those. Even the doctors prepared us for what was going to happen, that she would probably pass away. Every time she got sick, they would tell us that she might pass away.”

18. On 16 May 2014 the Do Not Resuscitate Order was removed by Ruby's foster carers. It was recorded that her carers were of the opinion that Ruby had a good quality of life despite her disability and that full resuscitation was required.

19. There had been plans while in Kununurra for Ruby to attend day care. That did not happen. But on return to Katherine she was able to attend Kintore Street School five days a week (when well). She did so for about two and a half years. She was much loved by those at the school. She was remembered fondly as a happy and smiling young girl.

20. On 9 October 2015, Ruby was admitted to Katherine District Hospital suffering pneumonia, having aspirated into her lungs. Her oxygen saturations were in the 60s and her carbon dioxide levels were 100 due to mucous plugging. She was put on high flow oxygen and initially responded. The high flow oxygen was weaned but she became drowsy and again recorded high carbon dioxide levels (100). She was clearly in respiratory failure and was evacuated to Royal Darwin Hospital.

21. By 13 October 2015 Ruby's condition was not stabilising and the family was requested to attend to discuss resuscitation and end of life options. One of the issues concerning the doctors was that if she was to be intubated there would be considerable difficulties weaning her off the oxygen.

22. The family attended on 16 October 2015. At the meeting there was the Paediatric Consultant and Registrar, the Clinical Nurse Manager, Ruby's mother, her grandmother, her father and his partner, the foster carer, a representative from Life without Barriers (through whom the carer was contracted), an aunty and a representative from Department of Children and Families.

23. The doctors spoke of the worsening scoliosis leading to increased risk of recurrent severe chest infections and the risk of her rapid decline. The

doctors said that both ICU and paediatricians recommended mechanical ventilation if required but not intubation. They said that if she was intubated she might have to remain intubated. The plan was for the family to discuss the issues and come to a decision.

24. By 3.00pm the family decided that she should not have invasive interventions. She would not be returned to Royal Darwin Hospital and her therapies should be restricted to oxygen. The Do Not Attempt Resuscitation order prepared read:

    - "For inhaled oxygen, suction, antibiotics + physiotherapy, escalating to high-flow by nasal cannulae, care delivered in Katherine, no transfer to Darwin.
    - No non-invasive ventilation (BIPAP).
    - No endotracheal intubation.
    - No external cardiac massage."

25. She substantially recovered and was discharged on 23 October 2015. However, that admission marked the start of a significant decline in her health. She was getting more saliva build up, leading to more coughing and choking and her scoliosis was having a significant effect on her breathing. Her doctors' trialled medication to reduce saliva production but her situation did not appear to improve.

26. On 21 March 2016 Ruby was admitted to Katherine District Hospital with what was thought to be aspiration pneumonia. She had oxygen saturations between 80 – 85% on room air. However there was no respiratory distress and she appeared to have reasonable air entry in both lungs. She was reviewed by the Consultant Paediatrician who was of the opinion that given her outlook there was no place for oxygen therapy. He said that could be reconsidered if Ruby became distressed due to hypoxaemia in the future.

27. On 5 June 2016 she was admitted to Katherine District Hospital with a persisting cough that she had been carrying for the last month. In the morning she was noted to have increased secretions and appeared distressed. She was commenced on medication in the evening to reduce the secretions. That appeared to stabilise her condition.

28. On Monday 25 July 2016 her carer took her to see her the General Practitioner at 8.58am. She told the doctor that Ruby had vomited on Friday night and Sunday morning. She had increased secretions over the last 24 hours and had been gagging that morning.

29. Her temperature was 36.6 degrees, her pulse at 125 beats per minute and her oxygen saturations 63%. Her breathing required increased effort. She was referred to Katherine District Hospital with likely aspiration pneumonia. The doctor said she likely needed intravenous antibiotics.

30. She was triaged at Katherine District Hospital at 10.23am. She was noted to have increasing shortness of breath and "work of breath" (effort to expand lungs). She was clammy and looking exhausted. Her oxygen saturations were 71% on room air and increased to 100% on 2 litres of oxygen per minute. The impression was that she had early aspiration pneumonia, dehydration and possible hyponatremia (low sodium).

31. At 2.12pm the oxygen therapy was ceased to monitor her oxygen saturations. She showed no respiratory distress. The plan was to keep her oxygen saturation levels between 85 – 95% but if the work of breathing increased then to change to high flow oxygen of up to 2 litres per minute.

32. At 8.00pm that evening she was on 0.5 litre per hour of oxygen and maintaining 90%+ oxygen saturations. Her work of breath was moderate and excretions not excessive.

33. The next day she seemed to be asleep although was responsive to torch light. However, by 11.52am her condition was noted to have changed. She was

less responsive, her blood gases showed her carbon dioxide levels had dramatically increased (from 78 to 139) and her PH levels were becoming more acidic (7.33 to 7.09).

34. Repeat blood gases were obtained at 2.52pm, they showed a worsening picture. Her carbon dioxide levels were unreadable and her PH was 6.86. She had not passed urine since the previous evening and her creatinine levels were elevated. It was clear that Ruby had gone into renal and respiratory failure and the family were called.

35. She died peacefully at 6.43pm that evening with family, carers, teachers (from her school) and medical staff present.

36. Her death was of natural causes and was expected. However, because she was in care at the time of her death an inquest was mandatorily required.

37. The coronial investigation found no issues with the care and treatment of Ruby and I find that the care, supervision and treatment of Ruby was appropriate.

Issues

38. However, issues arose in relation to the investigation and preparation for the inquest.

Police Investigation

39. I have become accustomed to the Police preparing high quality briefs for evidence in relation to deaths in care and custody. It is appropriate that be so given the death occurred while the person was under the control of a government institution.

40. Police General Orders also require that investigations into the deaths of children be supervised by the Superintendent Major Crime.

41. In this case the investigation was undertaken by a Detective, however it was his first coronial investigation and he was seemingly given little assistance or supervision. The consequence was an investigation that was still being undertaken days before the commencement of the inquest, almost a year after Ruby's death.

42. Fortunately, those issues were understood by the Police hierarchy. Assistant Commissioner Murphy provided an affidavit stating that further processes had been implemented that ensured a –

> "high level of supervision and monitoring of the progress of coronial briefs … whereby the Assistant Commissioner Crime and the Commander Crime will have overall oversight of the proper investigation of any death in care or custody, or unsolved suspicious death and preparation of the coronial brief to ensure a plan is in place for the brief's timely completion and that the investigation is objective, impartial, comprehensive and of a high standard."

Department of Children and Families/Territory Families

43. An issue that arose in this matter was that the Manager of the Department of Children and Families was unaware of the need to report this death. He suggested in his statement that as her death was expected he did not understand it to be a reportable death.

44. The death was only discovered after a request by the family was transmitted to the Coroner's Office some days later by a social worker at the hospital, unaware that the death had not been reported.

45. The Department undertook a review and among other things changed the template to prompt reporting to the Coroner's Office.

46. Another issue that arose was the difficulty in obtaining the original Departmental file. There may have been some misunderstanding by the manager of the Department's processes. However Counsel for the Department sought to press the point that the processes set up for all requests of the Department should be made to the Information and Privacy

unit who will then collect the files and electronic records and then supply them to the Coroner's Office. She said it couldn't be otherwise because the Department needed the original file.

47. The issue however was just that. The Investigating Police were told they would have to wait for the file until processed by the Information and Privacy Unit where various information within the file would be redacted.

48. The coronial process is an independent process. As I stated during the course of the inquest, it can hardly be independent if I am to rely upon what the Department is willing to provide to me at some time into the future.

49. If the current file in the Department's Office has information the Department requires at that time, it should be copied immediately so that the original file can be provided to the investigating officers when they call. The balance of the files and electronic records can then be provided over the next few days (I was told getting older files from storage can take two days).

50. I note that Counsel for the Department agreed that this could be done. This is not the first time these issues have been encountered and I am hoping it will be the last.

51. Having said that it is clear that the Department undertook a comprehensive review of the care and treatment provided to Ruby. I commend them on their willingness to review their processes and procedures to enable continuous learning and improvement.

52. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

    (i) The identity of the deceased was Ruby Blitner born on 28 March 2009 at Darwin, Northern Territory.

    (ii) The time of death was 6.43pm on 26 July 2016. The place of death was Katherine District Hospital, Katherine, in the Northern Territory.

(iii) The cause of death was respiratory failure from severe scoliosis due to Murray Valley encephalitis in the distant past.

(iv) The particulars required to register the death:

1. The deceased was Ruby Blitner.

2. The deceased was of Aboriginal descent.

3. The deceased was a student and not employed at the time of her death.

4. The death was not reported to the Coroner.

5. The cause of death was confirmed by Dr John Rutherford, Forensic Pathologist.

6. The deceased's mother was Courtney Chunama and her father was Daniel Blitner.

Dated this 10th day of August 2017.

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GREG CAVANAGH
TERRITORY CORONER