CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 10th, 11th, 12th and 13th days of April 2007, the 2nd, 3rd, 4th and 5th days of July 2007, and the 11th day of February 2008, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Elizjah Monique Ivy Lyden-Baker.

The said Court finds that Elizjah Monique Ivy Lyden-Baker aged 4 weeks, late of 61 Hamilton Road, Woodville North died at 61 Hamilton Road, Woodville North, South Australia on the 10th day of October 2004 as a result of an undetermined cause. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

1.1. Elizjah Lyden-Baker was born on 10 September 2004. The circumstances of her birth were unusual and I will return to them later. She spent the first three weeks of her short life in the Women's and Children's Hospital from which she was discharged on 2 October 2004. On the morning of 10 October 2004 Elizjah was found deceased in the lounge room of her grandmother's house by her mother Michelle Lyden. An autopsy was performed by Dr Karen Heath. A report of her findings was admitted as Exhibit C26. She was called as a witness in these proceedings. Dr Heath gave the cause of death in her autopsy report as "undetermined; possible suffocation – see comments". Under "comments" Dr Heath stated that her findings at autopsy "would be in keeping with the diagnosis of SIDS" however she qualified this by stating that "the finding of the infant face–down with her head in a soft pillow raises the distinct

possibility of asphyxiation due to suffocation". She then pointed out that there are no definitive anatomical markers for asphyxiation in infancy and so a diagnosis of asphyxiation, based purely on pathological findings, would be speculative.

1.2. Elizjah's mother, Michelle, gave evidence at the Inquest. She was the first person to find Elizjah on the morning of 10 October 2004. She described the position in which she found Elizjah. She stated that she knew something was wrong when she saw her:

> 'Her face in the pillow, like she had probably tried to turn it and got it stuck…[1]'

1.3. Michelle Lyden also said that Elizjah was lying on top of the pillow when she found her[2]. This evidence was consistent with a statement that Michelle Lyden had given to police shortly after Elizjah's death. A copy of that statement was available to Dr Heath at the time she performed the autopsy and wrote her report Exhibit C26. Dr Heath had the opportunity before giving her evidence to read the evidence of Michelle Lyden to which I have already referred, and was also shown some photographs which were admitted as Exhibit C14b. They depicted the position of Elizjah as apparently found by her mother. Dr Heath summarised her opinion having regard to all of this material as follows:

> 'All of those, the circumstances and the autopsy findings, are consistent with suffocation. However, whilst I can't rule out that she suffocated, I cannot also completely rule out that this infant died from SIDS, because there are a number of risk factors for SIDS in this family, or for this infant. So I can't attribute this death to SIDS because I can't rule out suffocation but, by the same token, I can't confidently say this infant did not die from SIDS'.[3]

1.4. Dr Heath also said that all that she had read since preparing her autopsy report did nothing to alter her opinion[4]. Dr Heath described the risk factors in Elizjah's case that would be considered relevant for a diagnosis of SIDS as including prematurity, poor socio-economic status, chaotic family environment, domestic violence and drug use in the mother (opiates)[5]. However, because SIDS is a diagnosis of exclusion, and because suffocation could not be completely ruled out, Dr Heath was precluded from reaching a diagnosis of SIDS.

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[1] Transcript, page 70
[2] Transcript, page 70
[3] Transcript, page 656
[4] Transcript, page 656
[5] Transcript, page 656

1.5. Against this background it falls to me to make a finding as to cause of death. Notwithstanding Dr Heath's view that suffocation was a possibility[6], having regard to the whole of her evidence and her report, it is my view that Dr Heath was not comfortable in concluding that the cause of death in this case was suffocation. She allowed that suffocation was a "strong possibility", but in the context of the whole of her evidence and her autopsy report I think that it would be wrong for me to find that Elizjah died from suffocation. Instead, I find that the first mentioned cause referred to by Dr Heath in her autopsy report Exhibit C26 is the appropriate finding, namely that the cause of Elizjah's death is undetermined. I find accordingly.

2. Circumstances of Elizjah's birth

2.1. According to the Women's and Children's Hospital casenotes for Elizjah which were admitted as Exhibit C21b, Elizjah arrived at the Women's and Children's Hospital in an ambulance with her mother. Her mother, Michelle, gave staff the following history. She was not aware that she was in labour and was on a pushbike intending to make a phone call at the nearest phone box at approximately 10:00pm on 10 September 2004. She said that she felt that she needed to go to the toilet when she realised that the baby was about to deliver. In fact the baby was delivered onto the head on the concrete pavement behind a tree. Michelle went to the nearest house for help and an ambulance was called.

2.2. This version of events was consistent with the evidence given by Michelle Lyden at the Inquest. The evidence also showed that on 13 September 2004 a notification was made to the Department for Families and Communities that Elizjah was a child at risk. This is evidenced by an intake form contained in the Department for Families and Communities file relating to Elizjah, which was admitted as Exhibit C17a. The intake form makes reference to the history of Elizjah's birth as described above. It also records that the notifier was seriously concerned about the mother's capacity to care for Elizjah on discharge from hospital given the mother's transience and drug addiction. Elizjah was treated for symptoms of drug withdrawal as a result of Michelle's drug use during pregnancy. Over the period of Elizjah's stay in the Women's and Children's Hospital she was gradually weaned off morphine on a

[6] At transcript 657 Dr Heath accepted that suffocation was a "strong possibility".

reducing dose to deal with her dependency.

2.3. The notification to the Department of Familles and Communities was made by Jayne Rickard the Senior Social Worker at the Women's and Children's Hospital. The evidence showed that on 13 September 2004[7] a meeting took place between Jayne Rickard and Michelle Lyden and Mr Laurence Baker who was the father of Elizjah. Mr Baker was himself an intravenous drug user and was homeless. Jayne Rickard gave the following account of this meeting. Michelle said that she had been homeless for approximately three months due to a combination of her financial problems, her drug habit, her inability to pay rent and a problem with a past relationship with a man by the name of Masters who was violent towards her. She had gone to a shelter but Mr Masters had found out where she was. She then stayed at various people's homes over a period of time. Her eleven-year-old daughter Lauren had not been at school during that period. Michelle admitted that she was dependent on heroin and described the amount that she was taking. When Ms Rickard raised future plans with Michelle and Laurence, Michelle was not really sure where she could go to live. At one point she suggested that she might be able to go to her mother's but both she and Laurence talked at length about the problems that they had had with Michelle's mother. Michelle talked about her childhood, her mother's drug abuse, her poor relationship with her mother, her mother being more alcoholic than drug addict these days. Michelle said that her mother hated Laurence and that represented a problem because they were together as a couple. On a number of occasions she said that she could not go and stay there with her mother but would have to go and stay with a friend. This meeting lasted for approximately an hour[8].

2.4. It was following this meeting that Ms Rickard made the notification to the Department for Families and Communities to which I have already referred.

2.5. The Women's and Children's Hospital made contact with Waranilla, which is run by the Drug and Alcohol Services Council, to advise of the situation. Michelle had had a past involvement with Waranilla and there was some prospect that she might renew her attempts at treatment for drug addiction with that entity.

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[7] Ms Rickard gave evidence at the Inquest. Between the time of the events relating to Elizjah's admission in the Women's and Children's Hospital and the date of the Inquest, Ms Rickard had changed her surname to McLaren. For convenience I will refer to her in these findings as Jayne Rickard.

[8] Transcript, pages 487-488

2.6. On 14 September 2004 Ms Sandy Petticrew, the Supervisor of the Family Assessment Services Team at Woodville office of the Department for Families and Communities allocated the notification concerning Elizjah to Mr Ryan Balkwill, who was a social worker employed by the Department at the Woodville district centre. Mr Balkwill had been employed at that point for approximately six months by the Department. Mr Balkwill was an inexperienced social worker at that point and Ms Petticrew allocated another more senior worker, Ms Jelena Senic[9] to assist in the management of the case.

2.7. On 15 September 2004 Ms Rickard contacted Ms Petticrew and left a message. It appears that Mr Balkwill rang Ms Rickard on the same date. On 16 September 2004 there was a telephone call between Ms Rickard and Mr Balkwill in which Ms Rickard understood that they arranged to meet later in the day[10]. Ms Rickard expected that Mr Balkwill would meet with her at around lunchtime. She cancelled a lunch appointment which she had previously made in order to facilitate the meeting with Mr Balkwill. At 3:30pm Mr Balkwill had not arrived and Ms Rickard made a telephone call to enquire what had happened. Mr Balkwill told her that he and Ms Senic had already attended at the Women's and Children's Hospital and had met with Michelle Lyden. Mr Balkwill had formed a view consequent on that meeting with Michelle, that Michelle could take the baby home to her mother's residence[11]. Ms Rickard expressed concern to Mr Balkwill about that plan[12]. In his evidence, Mr Balkwill stated that this conversation was limited to Ms Rickard expressing concern that he had not turned up for the meeting earlier in the day and denied that there was any reference to concerns about the proposal that Michelle take the baby to her mother's residence.

2.8. It appears to me on the evidence that from this early time, namely 16 September 2004, there was a preliminary view within the minds of staff of the Department for Families and Communities that it would be possible for Michelle Lyden to take Elizjah to the home of Michelle's mother, Theresa Topia-Lyden. This view gradually firmed over the ensuing weeks and ultimately, after her discharge from the Women's and

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[9] Ms Senic gave evidence at the Inquest. Ms Senic had changed her surname to Parkins. For convenience I will refer to her in these findings as Jelena Senic.
[10] Transcript, page 494
[11] Transcript, page 498
[12] Transcript, page 499

Children's Hospital Elizjah was living with Michelle in the home of Theresa Topia-Lyden.

2.9. The evidence of Ms Rickard was that she made several attempts to convey her concerns at the proposal that Elizjah be taken to live with her mother at her grandmother's house. It appears that she was persistent and firm in her view that this was not an appropriate plan.

2.10. On the other hand, Ms Petticrew, Mr Balkwill and Ms Senic were reluctant to accept that these views were so clearly conveyed, although Ms Petticrew acknowledged that she could not remember certain conversations and the evidence of the witnesses from the Department for Families and Communities was not as firm in relation to their recollection of events as that of Ms Rickard.

2.11. Much of the evidence at the Inquest was directed at who in fact was intended to be Elizjah's primary carer. Was it to be Michelle Lyden, was it to the Theresa Topia-Lyden (the grandmother)? The evidence was directed at the different understandings of the various protagonists as to what the situation would be. Ms Rickard's clear understanding was that Elizjah was to be discharged into the care of her mother and cared for by her mother Michelle and based on the information that she had, she felt that this clearly was not appropriate[13].

2.12. Michelle Lyden gave evidence to the effect that her mother's role would be to "take care of Elizjah or Lauren if anything was to come that wasn't good". She elaborated:

> 'If anything bad was to come, like if I stuffed up in some way and not doing the right thing, so looking after them.'[14]

Michelle Lyden was quite firm in saying that she was never told that Theresa Topia-Lyden was to be the primary carer[15].

2.13. Ms Theresa Topia-Lyden gave evidence at the Inquest. Her evidence was unsatisfactory. Her evidence was not completed on the day she was called and she was told that she would have to return to complete her evidence the following morning. She failed to attend for Court the following morning and despite making

[13] Transcript, page 503
[14] Transcript, page 47
[15] Transcript, page 78

contact about transport difficulties, she failed to reappear to complete her evidence in this matter. In my opinion she demonstrated by her conduct at the Inquest that she is not a reliable person and I treat her evidence with care. In any event, the thrust of her evidence was that she did not have the impression that she would be the primary carer for Elizjah although she said that she was more than willing for Michelle and Elizjah and Lauren to come and live with her.

2.14. Mr Balkwill gave evidence at the Inquest. His evidence as to the matter of who would be Elizjah's primary carer changed during the course of his evidence. His initial position was that Theresa Topia-Lyden was to be the primary carer. Under cross-examination he modified this position to one that aligned more closely with Michelle Lyden and Theresa Topia-Lyden's understanding, namely that Theresa Topia-Lyden's role would be to monitor the situation and step in if problems became evident.

2.15. Mr John Herselman gave evidence at the Inquest. He was the Acting Supervisor of the Woodville office of the Department for Families and Communities while Ms Petticrew was away for part of the relevant period. His clear understanding was that Theresa Topia-Lyden was to take on the primary care of Elizjah[16]. Ms Senic, the Acting Senior Practitioner who was assisting Mr Balkwill gave evidence that she understood that the grandmother Theresa Topia-Lyden would be the primary carer[17].

2.16. Prior to discharge of Elizjah, Michelle entered into an agreement with the Department for Families and Communities which was referred to as a "Safety Agreement". The agreement had no legal status but was used as a tool to guide the understanding of the parents and various other interested persons in relation to the safety of children in relation to whom notifications had been made under the Children's Protection Act. The document was the subject of a considerable amount of evidence. I do not propose to quote from the document. It can be found as apart of Exhibit C17a the Contact File for Elizjah kept by the Department for Families and Communities. The most obvious point to be made about the document is that it certainly did not reflect the stated understandings of Mr Balkwill, Ms Senic, Mr Herselman and Ms Petticrew that Theresa Topia-Lyden was to be the primary carer of Elizjah. My reading of the

[16] Transcript, pages 262-263
[17] Transcript, page 313

document was to the effect that Theresa Topia-Lyden's role would be to step in, in the event that Michelle was unable to properly care for Elizjah and apart from that, she would have a monitoring role. On the evidence, it appears that Theresa Topia-Lyden never saw this document[18].

2.17. Although the workers from the Department for Families and Communities appear to have intended that Theresa Topia-Lyden was to be the primary carer, this impression was not conveyed to Michelle or to Theresa Topia-Lyden. Nor was it clearly stated in the "Safety Agreement" – if anything, the agreement implied the contrary.

2.18. The evidence showed that Mr Balkwill and Ms Senic attended at the home of Theresa Topia-Lyden to interview her on 24 September 2004. This took place at Theresa Topia-Lyden's home. On this occasion she indicated her willingness to allow Michelle, Lauren and Elizjah to live with her.

2.19. There was a considerable amount of evidence about the circumstances in which Elizjah was discharged from the Women's and Children's Hospital on 2 October 2004. This evidence centred upon whether Theresa Topia-Lyden was present on this occasion or not. On the whole of the evidence it appears that she was present.

2.20. There was evidence of two home visits to the home of Theresa Topia-Lyden by Heather Hillgrove, a midwife employed by the Women's and Children's Hospital who conducts home visits. These visits occurred on 5 October 2004 and 6 October 2004. On the first visit Ms Hillgrove noted Elizjah to be overdressed. She advised Michelle in relation to the appropriate amount of clothing to be worn. She noted a weight loss of 95 grams that day. But the following day she noted that the weight had been regained. The note of the visit on 6 October 2004 stated "Babe settled and looks well."

2.21. Ms Hillgrove gave evidence that during the home visit it was not her practice, nor that of other midwives I infer, to check the sleeping arrangements for newborn babies.

2.22. I should also mention that it was the clear position of all relevant witnesses that it would not have been possible to have obtained an order under the Children's Protection Act for the removal of Elizjah from the guardianship and custody of

[18] Transcript, page 243

Michelle Lyden. The common understanding of all witnesses was that the relevant legislation, the Children's Protection Act, places a significant emphasis upon the need to maintain a family relationship around children the subject of investigation. I obtained the distinct impression that the various witnesses regarded this case as one in which they would have been most unlikely to procure an order for the removal of Elizjah. Submissions to a similar effect were made by Counsel for the Department and a number of other counsel. I proceed on the footing that the obtaining of such an order from the Children's Court was never a feasible option under the Children's Protection Act as it stands at present.

2.23. A number of photographs of the scene showing Elizjah in the position in which Michelle remembered finding her were taken by Brevet Sergeant Michael Heath. Brevet Sergeant Heath made a statement which was admitted as Exhibit C14a. The photographs appear as Exhibit C14b. They depict a lounge suite consisting of a padded sofa and two padded armchairs. The chairs and sofa appear to be covered in a vinyl type material. The condition of the material is poor and the covering is split in a number of places with the internal padding exposed. One of the armchairs was pushed up against the sofa such that the cushion of the armchair met the cushion of the sofa. There was a considerable amount of soft bedding on the cushion of the sofa and a soft pillow was placed on the cushion of the armchair. The sofa and the armchair met at right angles to one another and they formed an "L" shape. Elizjah was placed to sleep on the pillow on the cushion of the armchair which, as I have said, abutted the sofa which was covered in soft bedding also.

2.24. These sleeping arrangements are clearly unsafe as bedding for an infant. It is quite clear that an infant should be placed on a relatively firm surface with no soft cushions or other material upon which the child might be smothered. The safest place is clearly a cot or bassinet made up in accordance with safe sleeping guidelines.

2.25. It was on this soft pillow that Elizjah was placed to sleep on the night of 9 October 2004. It was in that position that she was found by Michelle Lyden on 10 October 2004.

3. Events following Elizjah's death

3.1. All of the relevant staff of the Department for Families and Communities and the Women's and Children's Hospital were clearly very distressed by Elizjah's death. Ms Rickard wrote an email on 13 October 2004 which was distributed to a number of staff within the hospital. In that email Ms Rickard outlined her concerns about the plan for Elizjah to be discharged with her mother into the home of her grandmother having regard to all of the circumstances known to staff at the Women's and Children's Hospital. This email was the subject of some evidence. It clearly caused some consternation with staff of the Department for Families and Communities. In particular, it appears that Ms Petticrew regarded it as an inappropriate personal criticism of herself and other staff.

3.2. In my view, the email was not expressed inappropriately. It is reflective of the concern felt by Ms Rickard and other relevant staff of the Women's and Children's Hospital. It does not contain any inappropriate or inflammatory language. It seems to me that it merely records, in a matter of fact way, the concerns felt by Ms Rickard and her criticisms of the approach of the Department for Families and Communities. I would not wish to discourage the frank exchange of views in the manner adopted by Ms Rickard.

3.3. On the other hand, I am unable to find any causal link between the acts or omissions of the staff of the Department for Families and Communities and the tragic death of Elizjah. I have been unable to determine a cause of death for Elizjah. Even had I found that her cause of death was suffocation, it would be drawing too long a bow to link that cause of death to any of the errors or omissions that were made by staff of the Department for Families and Communities. I do not say that there were no such errors or omissions, clearly there were. The "Safety Agreement" did not reflect the intended position. More work could have been done in assessing the suitability of Theresa Topia-Lyden as a potential carer for Elizjah. However, the staff of the Department for Families and Communities were constrained by the legislative tools at their disposal; the Children's Protection Act did not permit them to take stronger action for the protection of Elizjah. In particular, it did not permit them to take action for the removal of Elizjah from the guardianship and custody of Michelle.

3.4. Ms Rickard and the various staff members of the Women's and Children's Hospital on behalf of whom she forwarded the email, are all clearly passionate and dedicated to the welfare of children in general, and particularly the children who come under their care in the Women's and Children's Hospital. It is that passion and commitment which led to Ms Rickard taking the time to express her concerns in the email to which I have referred. The email was never likely to be welcomed by staff of the Department for Families and Communities. However, that does not mean that it was inappropriate. For my part I consider it useful and helpful that staff members involved in situations such as this feel free to express their views fearlessly and frankly. The clear expression of the point of view of a significant protagonist in a situation preceding an event such as the death of a child who has recently been the subject of a notification to the Department for Families and Communities can only assist subsequent investigations such as those carried out by South Australia Police for me and the Coroner's Court in this case. I commend Ms Rickard for her passion.

4. Recommendations

4.1. I have recorded that Ms Hillgrove said it was not her practice, nor that of other midwives who carry out home visits, to inspect the adequacy of the sleeping arrangements that exist for the infants in their homes. I make no criticism of Ms Hillgrove in this respect. Clearly it was no part of the home visit program to carry out any such inspection. However, it seems to me that it would be useful for midwives conducting home visits to satisfy themselves that safe sleeping practices are being employed within the home. No doubt this would entail further time and resources. Nevertheless, it is my view that safe sleeping arrangements are matters equally worthy of investigation as the physical clinical assessments which are routinely carried out on home visits. I recommend that the Minister for Health give consideration to providing midwives who carry out home visits the resources to enable them to check that safe sleeping practices are understood and being practised by the carers of infants.

4.2. I have found that I am unable to draw any causal links between acts or omission of Departmental employees and Elizjah's death. For this reason I do not feel that it would be appropriate to make a recommendation about the Children's Protection Act. Had it been otherwise, I would have done so. In my opinion it is extraordinary that

the Act would not permit the ready removal from the custody and guardianship of the mother of a child born in the appalling circumstances confronting Elizjah, born on a footpath with an addiction to the drugs thoughtlessly consumed by her mother during a pregnancy marked by a total failure to look after the interests of her unborn child.

Key Words: Family & Community Services - Dept of; Infant deaths; Unknown cause.

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 11th day of February, 2008.

State Coroner

Inquest Number 7/2007 (3072/04)