CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Port Pirie and Adelaide in the State of South Australia, on the 6th, 7th, 8th and 9th days of May 2008 and the 17th day of April 2009, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Jenisha Diandra Parrott (aka White).

The said Court finds that Jenisha Diandra Parrott (aka White) aged 7 weeks, late of 30 Fourth Street, Port Germein, South Australia died at Port Germein, South Australia on the 18th day of July 2004 as a result of streptococcus pneumoniae sepsis complicating retropharyngeal abscess. The said Court finds that the circumstances of her death were as follows:

1. Introduction

1.1. Jenisha Parrott and her twin brother, Joshua, were born by way of emergency caesarean section on 9 May 2004 at the Women's and Children's Hospital in Adelaide. They were born approximately 4 weeks prematurely.

1.2. On 28 May 2005 Jenisha and Joshua were both transferred to the Port Augusta Hospital where they remained until 26 June 2004 on which date they were discharged into the care of their parents, Janet Parrott and Jason White.

1.3. At the time with which this Inquest was concerned, the family lived at an address in Port Germein, which is approximately 27 kilometres from Port Pirie and approximately 70 kilometres from Port Augusta.

1.4. Jenisha Parrott died on 18 July 2004 at the Port Germein premises. She was 10 weeks of age at the time of her death. An autopsy was performed in respect of Jenisha's remains by Dr John Gilbert, a Forensic Pathologist. In his report[1] Dr Gilbert describes the cause of Jenisha's death as '*streptococcus pneumoniae* sepsis complicating retropharyngeal abscess'. I find that to be the cause of Jenisha's death.

1.5. During autopsy, dissection of the neck disclosed an extensive retropharyngeal abscess measuring approximately 4 x 4 centimetres in maximum dimension containing greenish, white purulent material. It was associated with a 2mm diameter perforation of the left lateral wall of the junction between the laryngopharynx and the upper oesophagus at the level of the cricoid cartilage[2]. In his comments, Dr Gilbert states that the appearances of the abscess were most in keeping with injury to the pharyngeal wall followed by the entry of bacteria into the soft tissues of the neck. The histological appearances of the abscess suggested that it had probably been present for about 5 to 7 days prior to Jenisha's death.

1.6. A retropharyngeal abscess is a rare infection[3], so much so that a general practitioner would be unlikely to encounter one in his or her entire career. For those reasons a GP would not be expected to diagnose a retropharyngeal abscess clinically. They are not readily seen upon an oral examination. This is not to say that an infant suffering from such an infection would go undiagnosed. There are general clinical signs of infection that would at least alert the practitioner to the existence of an infection. The site of the infection might remain unidentified until further examinations were conducted.

1.7. One of the possible causes of pharyngeal abscess is the forcible introduction deep into the throat of an object which perforates the back of the pharynx. The perforation created might then allow the passage of bacteria resulting in the abscess. The object could consist of, for example, a pencil, a stick or a spoon. I understood from the evidence that Jenisha, being only 10 weeks of age, was not being fed solid food. In addition, a feeding bottle could not inflict such an injury. When Jenisha was discharged from the Port Augusta Hospital she was prescribed Zantac for gastroesophageal reflux. This medicine is generally administered with a narrow 1mm plastic syringe. I was told that the appropriate way of administering medication with such a device is to place it between the cheek and the gums. However, if the device

[1] Exhibit C3a
[2] Exhibit C3a, page 3
[3] Dr John Harry, Transcript, page 386

was deliberately or inadvertently inserted deep into the throat, it could cause a pharyngeal perforation. In the normal course of administration there would be no need to insert the device to that depth. Zantac is a medicine that is given regularly. In Jenisha's case, the syringe is very possibly the only object that would have been regularly placed into her mouth. Although the evidence does not allow me to make any positive finding that the pharyngeal perforation was caused by this instrument, there is no evidence that any other object could have been responsible.

1.8. I add here that a retropharyngeal abscess may also arise naturally due to the spread of infection from other sites. However, Dr Gilbert suggests in his report that this would be an unlikely source of infection in this case because no such primary septic focus was identified at autopsy. However, he observes that a hidden natural source for the abscess could not be entirely excluded.

1.9. The evidence does not allow for any finding as to whether the injury was caused naturally, inadvertently or whether it was the product of excessive or maliciously inflicted force.

1.10. But there were other disturbing findings made at autopsy quite apart from the fatal retropharyngeal abscess. These included healing fractures of the right 3rd to 6th ribs in association with bruising of the overlying muscle. As well, there were healing fractures of both tibias that are bones of the legs. Radiological examination also indicated a possible fracture of the right distal femoral metaphysis. Dr Gilbert states that in his view, which I accept, these skeletal injuries were clearly the result of trauma and could not be accounted for by trauma that might be occasioned during childbirth. Histologically, the rib and tibial fractures were healing well with well-established callus formation indicating an age of at least 2 weeks[4]. They may have been older than this raising the theoretical possibility that the injuries could have occurred while the deceased was still in hospital, although I do not understand Dr Gilbert to be advocating that as a realistic possibility in this case. I note here that Jenisha had been in the care of her parents for just over 3 weeks, being the period between her discharge from the Port Augusta Hospital and her death. The injuries could therefore have been inflicted within that time frame.

[4] Exhibit C3a, page 12

1.11. Possible causes for the rib fractures include direct impact with the chest wall or chest compression. The tibial fractures could have arisen from compressive force applied along the long axis of the bone or possibly from forcible gripping. The femoral injury may have been due to direct application of force to the lower thigh or due to transmitted distractive or torsional forces.

1.12. The child's brain showed no evidence of recent traumatic injury. There were no skull fractures.

1.13. The cause of death, as seen, was the infection complicating the retropharyngeal abscess. No medical treatment was accorded to Jenisha for the fatal infection at any time prior to her death on 18 July 2004. Although to begin with the signs and symptoms of this abscess would not necessarily have been detectable, I am told that in the period of time immediately before Jenisha's death her well being would have been visibly deteriorating. Jenisha would in time have inevitably become profoundly and obviously unwell and have presented alarming symptoms to her parents.

1.14. Notwithstanding the difficulty in diagnosing a retropharyngeal abscess as the root cause of an infection, the evidence is, and I so find, that if medical treatment had been sought in this case the correct diagnosis would ultimately have been made in time for appropriate and lifesaving treatment to have been accorded to Jenisha. There is no reason to suppose that antibiotic treatment would not have had a significant therapeutic effect. It was by no means inevitable once this infection was contracted that Jenisha would die.

1.15. Three days prior to her death, a report had been received by the authorities in Port Pirie that Jenisha and her twin brother Joshua had been shaken. Jenisha's rib fractures, undoubtedly the result of impact or compression, would be in keeping with the act of shaking. The leg fractures were also the product of trauma. However, there were no other signs of shaking or trauma. It must be understood that shaking will not inevitably cause overt injury to the shaken infant. This would obviously depend upon the amount of force used and the duration of any such incident. Shaking can sometimes cause subdural haemorrhage which is bleeding on the brain. Permanent brain damage can also be caused. There was no evidence of any of that in this case in Jenisha. The only sign that would be in keeping specifically with shaking was her rib injuries.

1.16. Although no medical treatment had been administered to Jenisha prior to her death, she and Joshua had actually been medically examined by a local general practitioner in Port Pirie on 15 July 2004 in connection with the allegations of shaking to which I have referred. The doctor in question was Dr Hashim Ibrahim, a local general practitioner. It will be seen from my earlier analysis of the post mortem evidence that as at the time of these examinations, Jenisha had already contracted the eventually fatal throat lesion and as well, had suffered the skeletal injuries. As a result of the allegations, the infants had been taken to the Port Pirie Hospital by staff members of Child, Youth and Family Services (CYFS), an arm of the Department for Family and Community Services (the Department).

1.17. The allegation was that the infants had been shaken by their father. This allegation was the focal point of Doctor Ibrahim's examination. In his eyes, there was very little to indicate that either child had been physically abused and there was no visible or outward evidence of either child having been shaken. There is no dispute that both children at that time appeared to have been well and that is precisely the conclusion that the doctor came to. This conclusion was reached notwithstanding the then existence of Jenisha's abscess and skeletal injuries. The examination occurred at a time before Jenisha's undoubted overt deterioration. The children were returned to their parents following the examination and there they remained until Jenisha's death. I add here also that the day after Jenisha's death, the surviving twin Joshua was further examined at the Women's and Children's Hospital and was found to have subdural haemorrhages up to 14 days old and bony injuries including rib fractures, some of which were of an age of two weeks[5]. He was to survive those injuries. It is therefore likely that Joshua also had these injuries, again consistent with shaking, at the time of the medical examination of 15 July. Unfortunately, neither child was X-rayed as part of Dr Ibrahim's examination.

1.18. Although there is insufficient evidence to conclude positively that Jenisha's fatal pharyngeal abscess had been inflicted by way of violent, excessive or maliciously inflicted force, the finding is nevertheless a matter of concern, particularly in the context of the allegations of abuse that had been voiced three days prior to Jenisha's death, and especially having regard to the rib and bony leg injuries that were detected during the course of the post-mortem examination. The Inquest, however, did not

[5] Report of Dr Diana Lawrence, Exhibit C10f

directly seek to identify the person or persons who may have been responsible for Jenisha and her brother having been physically abused. In the event, I make no finding about that. The focus of my inquiry was whether or not proper attention had been paid by the relevant authorities to material that had been gathered that the children had been abused, and in particular shaken, and whether or not the proper and necessary investigative procedures had been followed. The other dominant issue was whether if those necessary procedures had been followed, the fatal abscess would have been detected.

2. The notification

2.1. On Thursday, 15 July 2004 the Port Pirie office of CYFS received a notification of alleged child abuse in respect of the children Jenisha and Joshua. The notification was recorded on a CYFS intake form that is reproduced in Exhibit C19 at pages 34 to 37. A document known as a 'Case Consultation Record' was also raised[6]. The notification was accorded Tier 1 status which implies high priority and the need for an immediate response.

2.2. The intake form recorded that a notifier, whose identity can be revealed as Jenisha's mother's sister[7], had reported that on the previous evening the mother had contacted her and was very upset and concerned. The mother had told her sister that the father of Jenisha and Joshua had been shaking the babies. In particular, on that previous evening he had been shaking Joshua and as a result the mother had noticed blood coming from the baby's mouth. Indeed, Joshua had a torn frenulum. The notifier advised that, according to the children's mother, the father had been very stressed out and was hanging out for drugs as he is a heavy marijuana user and that in the past few days he had been 'taking it out on the babies'. It was alleged that the father had also shaken Jenisha causing Jenisha to cry. It is recorded that the notifier was unable to provide any further specific information regarding the current health of the two children.

2.3. An assessment made that day by CYFS was recorded as follows:

> 'The information contained within this intake is very concerning.
>
> Given allegations that both babies have been shaken by father, causing
>
> Jenisha to cry and Joshua was observed to be bleeding from the mouth.

[6] Exhibit C19, page 15

[7] The identity of the notifier is revealed by virtue of the order of this Court made pursuant to section 13(4)(b) of the Children's Protection Act 1993 as the notifier has consented to the admission of evidence of her identity in these proceedings

> These babies are considered to be in imminent danger, therefore an immediate response is required by FAYS.'

2.4. The intake also records that the notifier, who lived at Coober Pedy, was nevertheless able to provide the mother with support and was able to care for the babies if required.

2.5. The case consultation record, which is a handwritten document signed by a Mr Paul Castle, the CYFS supervisor and a Ms Jenny Grainger who was to become the primary caseworker in respect of this notification, records as the decided prospective action:

> 'Immediate home visit to the family home at Pt Germein with Aboriginal Health Worker, Carol Warren, if available.
>
> - Assess parent/child interaction plus identify supports to the family
> - Both children to see their GP/Pirie Hospital GP today
> - Sharon Schroeter to H.V. (home visit) also to assist with children if parents/parent chooses not attend Hospital with children
> - Contact Supervisor if parents unwilling to have children medically assessed as consideration and consultation with RG. + PSW re section 17 if parents refuse medical attention
> - If any concerns by Dr. re medical assessment, C.P.S. (Child Protection Service) to be contacted to arrange further assessments.'

2.6. The reference to section 17 in the above extract is a reference to section 17 of the Children's Protection Act 1993 (the Act). This provision, as it was then framed, enabled a member of the police force, or an officer of the Department with the prior approval of the Chief Executive Officer of the Department, to remove a child from the child's guardian or guardians where the officer believed on reasonable grounds that the safety of a child who was in the company of the guardian or guardians was in imminent danger and that the child was at risk[8]. One of the issues explored in this Inquest was whether this power ought to have been utilised in respect of Jenisha and Joshua in this instance.

2.7. The notification that I have described is the first such notification that had been received by CYFS in respect of either of these children.

[8] The existing corresponding provisions are now contained within section 16 of the Act

3. The home visit to the Port Germein premises

3.1. Two CYFS workers, Jennifer Grainger and Sharon Schroeter, travelled from Port Pirie to Port Germein for the purposes of conducting a home visit at the premises occupied by Jenisha and Joshua's parents. They arrived at the premises sometime in the afternoon of that day. At approximately the same time Ms Carol Warren, who was an Aboriginal hospital liaison worker with the Port Pirie Regional Health Service, also arrived. Ms Grainger was the principal officer in respect of this investigation. Ms Schroeter had a supporting role. The two officers had conferred with the local Port Germein police officer before they attended the premises. I understood that the purpose of attending the police station was to alert police as to the possible need for police support, although it is clear that police were not intended to take part in the investigation of the notification at that time.

3.2. Both babies and their parents were present at the premises as was the children's grandmother.

3.3. Ms Grainger, Ms Schroeter and Ms Warren, all gave evidence in the Inquest. Ms Grainger and Ms Warren gave differing versions as to what was said by the children's mother in response to the allegations of abuse. I add here that the mother's English, while existent, was less than perfect. Ms Warren was able to converse to the mother in her own Aboriginal dialect.

3.4. Ms Warren told me that she did not know that there had been a complaint of child abuse in respect of the twins at any time before her arrival at these premises. She was there made aware for the first time of the allegation that the father had been shaking the children, or at least one of them. Although there is reference in the CYFS extract reproduced above that CYFS intended to enlist Ms Warren's assistance, I understood that it was purely fortuitous that Warren arrived at the house at the same time as the CYFS workers. Ms Warren attended in her capacity as a health worker.

3.5. Ms Warren told me that when Ms Grainger asked the mother in English whether the babies had been shaken, the mother replied affirmatively. She then spoke to Ms Warren in a dialect. According to Ms Warren, the mother told her that the baby or babies had been shaken but went on to make excuses for her partner's behaviour in that regard. Ms Warren said that the mother told her that she and her partner would argue and as a result he would become angry with her and the babies. Ms Warren

said, however, that the mother did not specifically say that the partner had shaken the babies, but that he had simply become angry, especially when he was 'hanging out for marijuana, or stressing out for marijuana'[9]. Ms Warren told me that she then told the CYFS workers what the children's mother had told her in dialect. In cross-examination Ms Warren more specifically suggested that she had passed this information on to Ms Grainger. Ms Schroeter may have been inside the house at that stage.

3.6. The evidence of Ms Grainger was at odds with that of Ms Warren. Indeed, save for one gesture made by the mother that I will describe in a moment, as far as Ms Grainger and Ms Schroeter were concerned, there was no acknowledgement at any stage by any person that the babies or either of them had been shaken. Ms Grainger told me that the allegations were explained to the mother without the mother being asked specifically whether she agreed or otherwise with those allegations. She could not recollect any conversation in an Aboriginal language as having taken place between the mother and Ms Warren but, owing to a general deficiency of recall about the event as a whole, acknowledged that she was in no position to deny that such a conversation might have occurred. However, Ms Grainger strenuously denied that Ms Warren had told her that the father had become angry when stressing out for marijuana. Ms Grainger told me that this was the kind of information that would have significantly changed the nature of her assessment because the acknowledgement of violent or aggressive behaviour within the home would have meant that there had been an identified risk factor connected with the original allegation. It was information that she would have regarded as crucial. The same would clearly apply to any suggestion that the father had taken his anger out on the children. As to what difference that piece of information may have made, Ms Grainger gave me to understand that the information would have been highly relevant in forming a later decision whether to admit either of the children to the local hospital overnight and/or to engage the Child Protection Service at the Women's and Children's Hospital (the WCH) and have the children transported to Adelaide for that purpose.

3.7. It is hard to disagree with the view expressed by Ms Grainger that the kind of information allegedly imparted by the mother to Ms Warren in an Aboriginal dialect

[9] Transcript, page 258

would have been central to her inquiry and possibly determinative of the outcome later that day or the following day.

3.8. As to whether that information was imparted to Ms Warren, and then relayed to either Ms Grainger or Ms Schroeter or both, both women gave evidence that neither was made aware of any admission of shaking or other abuse when they were at the Port Germein premises. In fact, the witness statements of both women suggest that the twins' mother appeared to be 'at a loss for words' in respect of the broad allegations[10].

3.9. At the premises it was agreed that the children could be taken to Port Pirie for a medical examination and, as it transpired, the children's mother travelled with them to the Port Pirie Hospital where the examination later occurred. Although according to the CYFS officers nothing in the way of an admission by any person had occurred at the premises, and no other evidence of abuse was discovered there, an incident took place in the car enroute to Port Pirie from which one's suspicions about the children having been shaken could only have been heightened. Both Ms Schroeter and Ms Grainger report that when the allegations were discussed in the car, the children's mother at first stated that the father had not shaken the baby, but during further discussion indicated verbally that the father had in fact shaken the baby. Ms Grainger asked the children's mother if she could demonstrate how the father shook the baby and in the statement of Ms Grainger the response is recorded as follows:

> 'Janet demonstrated with her arms up and a slight movement forward which did not indicate a shake or shaking motion.'

In her evidence, Ms Grainger elaborated on what the mother had indicated. Ms Grainger demonstrated that the mother had held her hands up and had made a slight movement with them which Ms Grainger described as 'just a twitch of the hands'[11]. Ms Grainger told me that the movement that the mother made was not actually a shaking movement. Ms Grainger told me that she did not believe that the mother's demonstration had significantly corroborated the complaint. She said:

> 'I took into account the fact that we were welfare and that we probably scared them, and that I was unsure of whether she was actually trying to tell us what we wanted to hear, or was telling me what actually happened.' [12]

[10] Exhibit C25, page 3 and Exhibit C26, page 3
[11] Transcript, page 108
[12] Transcript, page 109

Whatever interpretation was to be placed on the mother's demonstration, and it has to be said that at the time views might well have differed about its true significance, as far as Ms Grainger and Ms Schroeter were concerned it constituted the only thing of relevance as to whether the allegations were in any sense substantiated.

3.10. It is difficult to resolve the discrepancy between Ms Warren's evidence and Ms Grainger's evidence about what the mother had said at the house. Both witnesses impressed me as being honest and candid. Neither woman's version of events was inherently unlikely. While accepting Ms Warren's evidence that there was some acknowledgment by the mother to her that there had been a measure of agitation exhibited by the father towards the children short of shaking, I am not satisfied that this conversation in the Aboriginal language was conveyed faithfully to Ms Grainger in English. To my mind it is unthinkable that a person of Ms Grainger's experience would have ignored such an intimation for the reasons that she articulated in her evidence – namely that she would have regarded the information as extremely important, almost carrying the day as it were, about what they should have done. Furthermore, it is the kind of information that Ms Grainger was endeavouring to secure as far as corroboration of the initial notifier's complaint was concerned and it is difficult to accept that such a piece of information would have been ignored. I have not overlooked the possibility that in the light of the tragic events that were to unfold in respect of Jenisha in the next few days, that there may be a motive on the part of Ms Grainger to suppress that piece of information if it had been imparted to her at the time of her original home visit. However, the motive to conceal important information relevant to her official duties would only have arisen on 18 July 2004, the date of Jenisha's death. Documentation that was created by Ms Grainger and Ms Schroeter that forms part of CYFS records and which apparently was compiled on the afternoon of 15 July 2004, the day of the home visit, does not refer to any such information. One would have expected it to if it had been imparted by Ms Warren to Ms Grainger. There was no need for Ms Grainger to have suppressed relevant information at that time. On the contrary. This was precisely the sort of material Ms Grainger had been looking for and she would have had every reason to record it if it had been imparted to her. I am also mindful of the fact that in the extremely comprehensive adverse events review report[13] that was compiled by the Department in the aftermath of this affair, there is an absence of any reference to a conversation in an

[13] Exhibit C26a

Aboriginal dialect between Ms Warren and the children's mother. It is apparent from the report that Ms Warren was interviewed as part of the review and I am prepared to infer that the absence of any reference to this information in the report is a reflection of the fact that Ms Warren did not share it with the reviewing panel.

3.11. I am not satisfied that Ms Warren at any time gave Ms Grainger to understand that the children's mother had told Ms Warren about the propensity of the father to lose his temper with her and the babies.

4. The medical examination

4.1. The medical examination was conducted by Dr Hashim Ibrahim who was a local Port Pirie general practitioner who had practising rights at the Port Pirie Hospital. He was one of a number of local practitioners who, pursuant to a roster, were on-call to attend at the hospital if necessary.

4.2. Dr Ibrahim undertook his primary medical training in Zimbabwe between 1980 and 1984. His postgraduate training was also undertaken in that country. He studied internal medicine for 4 years from 1996 to 1999. He has a Masters Degree in internal medicine. He moved to the United Kingdom. He completed an MRCP in 2002 before coming to Australia in May of that year. I understand that from that time onwards Dr Ibrahim practised in Port Pirie before moving to Brisbane in February 2006.

4.3. The presentation of Jenisha and Joshua on 15 July 2004 was the first occasion on which Dr Ibrahim had responded to a CYFS request to examine an infant reportedly the subject of abuse. Dr Ibrahim had never had occasion to consider, in any detailed clinical sense, what the external or internal manifestations of shaking might be. Indeed, Dr Ibrahim had received no training or education about child abuse and possible signs and symptoms of the same. In particular, he had not received any training in respect of 'shaken baby syndrome' or the symptomatology of that. Dr Ibrahim did not have any specialist knowledge or understanding of what one should be looking for in an allegedly shaken baby. While it is true that in serious cases of shaking there might be obvious outward signs, particularly in relation to the child's level of consciousness, the more subtle signs that are not revealed by an external examination would be simply undetectable to anyone other than an expert. Dr Ibrahim was no such expert and he never held himself out to be such an expert.

4.4. Another circumstance that operated to Dr Ibrahim's disadvantage in conducting this examination was the fact that he was used to examining patients, and evaluating signs and symptoms in those patients, in the context of a clinical presentation, no doubt prompted by a parent having detected something wrong with their child. This was not the case here. Dr Ibrahim was asked to examine these children in the investigatory context of general allegations of shaking that were thus far uncorroborated and lacking in clinical support. In such a setting, therefore, it would not be surprising that if Dr Ibrahim, based on his experience as a GP, concluded that both children were normal and not unwell, subtle abnormalities might go unobserved or their significance not be truly appreciated. In my view it is impossible to think less of Dr Ibrahim simply because he did not pick up on a potentially fatal infection in an outwardly healthy infant when he was asked to look for evidence of something quite unrelated. And as I say, he was not an expert in child abuse.

4.5. The principal social worker, Ms Grainger, was not present while Dr Ibrahim's examination took place. During the course of the examination she was conferring with her supervisor about what they should do next. Ms Schroeter was present during the examination. In any event, as I understand the evidence neither woman knew anything about the possible symptomatology of shaken baby syndrome. Accordingly, there was really nothing within the four walls of the Port Pirie Hospital that afternoon to guide Dr Ibrahim as to what he ought to be looking for.

4.6. I do not need to go into the fine detail of Dr Ibrahim's examination. He detected nothing that in his experience was concerning in respect of either child. It needs to be steadily borne in mind that the pathology that eventually claimed Jenisha's life, although undoubtedly present at the time of this examination, was neither suspected, looked for nor detected. The evidence before me would suggest that it is by no means certain that an examination in respect of an allegation of a shaken baby would reveal something as unusual as a retropharyngeal abscess. For instance, the retropharyngeal abscess would not be revealed simply by an examination of the child's throat.

4.7. However, there were two abnormalities with respect to Jenisha's vital signs that were detected upon the nurse's initial examination. The child had a pulse rate of 168 beats per minute and a temperature of 35.9ºC. The pulse rate was slightly elevated and the temperature was lower than normal. Although these revelations could have had no clinical relevance in the context of an allegation that the child had been shaken, I was

told in evidence by Dr John Harry, a medical practitioner with wide experience in the medical assessment of children in whom child abuse and inflicted injury has been suspected, that this may well have generated in the mind of an examining medical practitioner the possibility that an infection was present in the child[14]. As it happens there was an infection in this instance, being the retropharyngeal abscess. Specifically, I was told that a lower than normal temperature in infants might well be a reflection of an infection that was severe. One could readily understand a medical practitioner suspecting the presence of an infection from these figures if one were examining a child in circumstances where there was evidence of overt illness and that this was the reason for the child's presentation. However, the nature of Dr Ibrahim's examination was an investigation for evidence of shaking and, given that the child appeared to be completely well, the lower temperature and the higher than normal pulse rate would have had limited significance to a person not used to examining children in the context of allegations of abuse. In my view it is difficult to reach any conclusion other than that while in hindsight it would have been appropriate for Dr Ibrahim to have considered the possibility of an infection, it is somewhat of a counsel of perfection to suggest that he should inevitably have considered it. In his circumstances and with his experience and training, it was by no means unreasonable for Dr Ibrahim to have regarded those abnormalities as not of significance in the overall clinical context.

4.8. Neither child was subjected to an X-ray or a CT scan. An X-ray could and should undoubtedly have been performed in respect of both children. An X-ray would have revealed the fractures in respect of both Jenisha and Joshua. In particular, in the context of an allegation of shaking, Jenisha's rib fractures would have been a significant revelation. Even if the rib fractures could not directly be assigned to shaking, their presence alone would have been highly suggestive of the application of excessive physical force at the hands of another person, and the leg fractures would no doubt have reinforced that impression. A chest X-ray in this particular case might also have serendipitously demonstrated swelling in the neck from the developing retropharyngeal abscess. In short, there would have been no room for doubt in the minds of either the medical practitioner or the social workers that abuse had occurred. The allegations of shaking would in those circumstances have been corroborated and the necessary removal of the children would then have been able to occur.

[14] Report of Dr Harry, Exhibit C27

4.9. The evidence persuaded me that X-rays should be performed as a matter of course, at least of the chest, where an allegation of shaking has been made. Although rib fractures will not necessarily be sustained following shaking, their presence would be a matter of momentous significance in the context of such an allegation. For that reason, an X-ray of an infant said to have been shaken ought to be considered mandatory as part of any medical examination. Again, there is no evidence to suggest that either Dr Ibrahim or the social workers understood the presence of rib fractures as being a possible sign of shaking. This to my mind gives rise to the need for education to be delivered to medical practitioners and social workers who might be asked to consider and evaluate allegations of infant shaking.

4.10. Dr Harry was of the view that in any event, and especially considering the allegations of shaking in conjunction with the unusual findings in respect of Jenisha's pulse rate and temperature, that the children should have been placed under observation. In this regard, throughout the course of the Inquest I was slightly troubled by the fact that the eventual cause of death was something other than, and quite divorced from, the specific allegation of shaking and that the Court was in effect being invited to be wise after the event. It is a valid observation that the existence of the retropharyngeal abscess would only have been a fortuitous revelation if Jenisha had simply been kept under medical observation in respect of an allegation of shaking. However, I was persuaded that the matter should not be viewed so simplistically. In regard to the potential evidentiary value of an abnormal temperature and pulse rate in the context of an allegation of abuse, Dr Harry said this:

> 'It should be viewed as not being normal. It also I think should be viewed as not really explicable by the baby being shaken and therefore perhaps if there's some other reason for the low temperature and the high pulse rate, in other words just because the baby is said to have been abused or shaken you can't sort of exclude all other possibilities, you have to think about something else. You are looking at the whole baby not just the baby's head and eyes, so the baby might have been shaken but it may well have other significant problems, as of course this baby - in fact this baby also had a fracture in his tibia as well which was not recognised at the time. Shaken babies, babies who are in a situation where they are subject to abuse are more likely to have other problems as well.'[15]

To my mind there is much validity in Dr Harry's observation. In my opinion those whose task it is to investigate allegations of child abuse, and this includes medical practitioners called upon to examine the subject children, should not see themselves as straight jacketed by the specific allegations of abuse. There is a lot to be said for

[15] Transcript, pages 346-347

the suggestion that a child that has been abused in a specifically identified manner may well have been abused in other ways, or have been subjected to an environment that has not altogether been conducive to his or her well being in general. As Dr Harry pointed out, in this particular case the family background was obviously not good and in the light of that he would have had admitted the baby to hospital and undertaken further investigations. He would also have kept in mind that the low temperature and high pulse rate were reflections of something else going on with the baby quite apart from the allegations of shaking. The investigations that Dr Harry had in mind were an X-ray of both children and possibly even a CT scan. The revelations of an X-ray in respect of Jenisha and/or Joshua would have meant that the children would have been referred to the Women's and Children's Hospital in Adelaide.

4.11. The other matter that Dr Harry raised, that was in my view also a worthwhile and valid observation, was that allegations of shaken baby can seldom if ever be confidently refuted in a clinical setting. Even where the baby has undergone the full range of investigations without any abnormality having been detected, this does not prove that the baby has not been shaken. In fact most babies who are shaken do not have any physical signs or symptoms.

4.12. It is clear to me, and I so find, that the failure to administer X-rays to the two children was a significant failure. The need for X-rays was triggered by virtue of the allegations of shaking alone, quite apart from any abnormality in the vital signs of Jenisha. The revelation of the broken ribs in themselves would have dictated a different outcome altogether. She would no doubt have been transferred to the Women's and Children's Hospital for further evaluation. To my mind the evidence is clear, and there is no reason to suppose otherwise, that the retropharyngeal abscess would almost inevitably have been detected and diagnosed in due course and that the deceased's chances of survival would thereby have been magnified immeasurably.

4.13. The failure to conduct X-ray examinations was borne out of ignorance on the part of both Dr Ibrahim and the social workers about the possible manifestations of shaken baby syndrome. I do not say that critically. They simply did not have the necessary knowledge or training in that regard.

4.14. In the event, Dr Ibrahim reported both children as being healthy with no obvious sign of injury.

5. Events following the medical examination

5.1. While the medical examination had been taking place, Ms Grainger had been conferring with her supervisor. A determination had been made that in the event that the allegations were corroborated by the medical examination, the children would have been removed pursuant to the provisions of the Children's Protection Act. However, the eventual medical report that both children were healthy, with no obvious signs of injury, meant that there was no properly perceived foundation for any further action on the part of CYFS and that is the way the matter was then seen and recorded. On the intake form[16] it is recorded that the abuse was "not confirmed". The children were accordingly placed back into the care of their parents and taken back to Port Germein. Certain sociological measures were put in place that were obviously thought to be safeguards against any other adverse events. I do not need to record the details of that here. There is no evidence that any person in authority saw either child over the ensuing three days over which Jenisha must have visibly deteriorated.

5.2. At the time with which this Inquest was concerned a number of procedures and guidelines that related to the processing and investigation of notifications of alleged child abuse had been in place. In particular I refer to the Interagency Code of Practice that was annexed to the affidavit of Mary Ann Carver[17]. Ms Carver is the Manager, Policy and Strategy, Child Protection Directorate, Familles SA, Department for Families and Communities. Families SA is the current manifestation of CYFS. The document stressed the need for agency collaboration in any investigation or assessment of an allegation of child abuse. The document specifically identifies:

> 'The need for coordination and a collaborative approach between each agency involved is of vital importance in helping to ensure that actions and decisions are made in the best interests of the child.' [18]

One of the relevant agencies was, and still is, the Child Protection Services. This organisation is a Government funded entity that comprises two services in South Australia that are designed to assess and treat infants, children and adolescents up to the age of 18 years when it has been alleged that a child has been physically, sexually and/or emotionally abused or neglected. The services were located in the Women's

[16] Exhibit C19
[17] Exhibit C29, Annexure MAC2
[18] Exhibit C29, Annexure MAC2, page 32

and Children's Hospital and the Flinders Medical Centre and were available at the time with which this Inquest is concerned. The evidence suggested that not only does Child Protection Services provide such treatment and assessment, but provides an 'around the clock' advisory service staffed by experienced medical practitioners that is available to members of other agencies concerned in the assessment of an allegation of child abuse including general medical practitioners. The service as I understand it would have been available to Dr Ibrahim if he had chosen to avail himself of the service and had sought advice.

5.3. The document also envisages that in Tier 1 cases, as this was, a 'strategy discussion' that involved police and Child Protection Services would be called immediately and would usually involve the CYFS supervisor and the allocated caseworker, in this case Mr Castle and Ms Grainger respectively. The strategy discussion is said in the document to be 'the corner-stone of planning the initial interagency response'[19]. The purpose of the strategy discussion is, in general terms, to coordinate a multi-agency approach to the child protection and criminal investigation and will consider such matters including all the known information about the child and the family to determine the immediate response required and to develop an investigation plan. The strategy discussion was mandatory in respect of Tier 1 rated notifications. The responsibility for convening and conducting the strategy discussion was placed upon the Department in Tier 1 classifications. It will be seen that it was envisaged that Child Protection Services would be brought into the investigation from the very beginning. This meant in Jenisha's case that the strategy discussion, and therefore involvement of Child Protection Services, ought to have taken place before the medical examination.

5.4. It is common ground that no such strategy discussion as envisaged by these documentary procedures took place in Jenisha and Joshua's case when it should have. Ms Grainger readily conceded that this was the case. This meant that Child Protection Services were not involved either at the beginning of this investigation or at any other time having regard to the eventual negative outcome of Dr Ibrahim's examination. Although there was no reason why Dr Ibrahim, as a qualified medical practitioner, should not have carried out the medical examination, there is no question but that before his examination took place, Child Protection Services should have

[19] Exhibit C29, Annexure MAC2, page 51

been involved and should have been advising Dr Ibrahim as to the nature and extent of his examination - but the Service was not consulted. Had that occurred, there is no reason to suppose that an X-ray of the two children would not have been ordered. I have already referred to what the inevitable outcome of an X-ray of Jenisha would have been, namely the detection of the bony injuries including broken ribs, a corroborative piece of information in the context of an allegation of shaking. A chain of events would thereby have been established that would almost inevitably have culminated in a timely and effective diagnosis of the fatal abscess in Jenisha.

5.5. The lack of any strategy discussion in the case meant that Dr Ibrahim's examination always ran the risk of being and uninformed and inadequate one and this turned out to be the case.

6. Recommendations

6.1. Evidence was placed before me that since the incident with which this Inquest was concerned a number of changes have been made with respect to Families SA protocols and practices in respect of child protection policies. This is described in the affidavit of Mary Ann Carver[20]. Many of the procedures outlined in the copious documentation attached to the affidavit do not directly concern the issues that were alive in this particular Inquest. There is still the need for strategy discussions in any Tier 1 notification. However, there is now greater emphasis placed upon the importance of the medical assessment and it is specifically stated that it is critical that the Child Protection Services medical staff are involved in the medical assessments of infants where there are allegations of physical or sexual abuse. Exhibit C29, Annexure MAC 7, page 19 points out the existence of recent cases where serious injuries had resulted in deaths to infants but which had not been detected on examination by non-specialist medical staff. Clearly Jenisha Parrott's death falls within that category. The document also acknowledges that medical staff need to be 'suitably qualified' to perform the necessary medical assessments. Specifically, the document states as follows:

> 'Where there is an allegation or suspicion that the infant may have been physically abused and/or shaken, the infant must be assessed by Child Protection Services medical staff. In cases where this is not possible, as a minimum standard, Child Protection

[20] Exhibit C29

> Services medical staff must be consulted regarding appropriate medical assessment of the infant.' [21]

Had that stipulation been in existence at the time Jenisha and her brother were presented to the Port Pirie Hospital, there is little doubt that Dr Ibrahim would have at least been advised by CYFS staff to seek out the Child Protection Services' medical expertise. I do observe, however, that even under the protocols that existed at the time it does seem quite clear that a properly held strategy discussion would have culminated in the involvement of Child Protection Services in any event.

6.2. I agree with counsel for the Department that there is no need to make any further recommendation as far as Families SA protocols are concerned. However, I have already referred to what, in my view, is a need for Families SA staff and general medical practitioners to be educated in respect of the signs and symptoms of shaken baby syndrome.

6.3. As well, the involvement of rural specialist paediatricians to be consulted in difficult cases that arise in the country as this one did is also considered to be desirable. If a medical assessment such as this needs to be carried out in a rural setting, the examination ought to be carried out by a specialist if available. The evidence revealed that in this instance there was a paediatrician who practised in the region. The evidence was not clear about his availability or otherwise on the occasion in question, but it does not seem to have occurred to anyone that it would have been a good idea for him to have been sought out and consulted rather than the inexperienced Dr Ibrahim. The desirability of having genuine expertise available in a rural setting could also be met by the appointment of suitably medically qualified and trained regional Children's Protection Service representatives who are resident and who practice medicine in the various rural regions.

6.4. Pursuant to section 25(2) of the Coroner's Act 2003, I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

6.5. I recommend that the Minister for Health and the Minister for Families and Communities work together to ensure that Families SA workers and general medical

[21] Exhibit C29, Annexure MAC7, page 20

practitioners are educated as to the symptomatology of shaken baby syndrome and, in particular, in respect of the need to perform X-rays whenever such an allegation is made.

6.6. I further recommend that the same Ministers consider appointing suitably qualified and trained medical practitioners as Child Protection Service representatives for each rural region in South Australia.

Key Words: Child Protection; Child Abuse; Families SA; Inadequate Examination

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 17th day of April, 2009.

Deputy State Coroner