STATE
CORONER
VICTORIA

7th April, 2003Case No: 4197/00

RECORD OF INVESTIGATION INTO DEATH

I, **LEWIS PHILLIP BYRNE**, Coroner,

having investigated the death of ELIANA DISKIN without holding an inquest,

find that the identity of the deceased was ELIANA DISKIN and that the death occurred on the 26th December, 2000 at Royal Children's Hospital from disseminated candidiasis secondary to the effects of malnutrition

in the following circumstances:

The deceased was born on 8th July 2000 at Geelong, the first child of Marcus and Ora Diskin. Initially, Mrs. Diskin breast-fed baby Eliana. The local Maternal and Child Health Nurse Judith Haigh commenced contact with Eliana and Mrs. Diskin at the latters workplace, Diskin

Chiropractic Clinic, where she returned to work immediately upon leaving hospital. The contact was a variation on a home visit. On the first two visits Ms. Haigh examined Eliana and considered her progress satisfactory. At the visit of 9th August 2000, Mrs. Diskin advised Ms. Haigh that she had concerns about baby formulae and due to the fact she herself was allergic to the traditional baby formula, she had begun substituting one breast-feed per day with an imported American rice milk product. At a subsequent routine attendance upon Dr. Jennifer Barker at the Sherton Medical Practice, Mrs. Diskin advised Dr. Barker about the supplementary rice milk feed, or more precisely the substituted rice milk feed. To those who expressed reservations about the nutritional value of the rice milk being fed to Eliana, Mrs. Diskin said that on advice from a naturopath associated with her husband's clinic she was adding vitamin and mineral supplements to the rice milk. Again on 4th September, Nurse Haigh examined baby Eliana and again noted good developmental growth. It is important to understand at this time Mrs. Diskin was still breast-feeding Eliana and whatever rice milk was being provided was by way of supplement. In mid September a friend / acquaintance of Mr. & Mrs. Diskin, Dr. Tony Graj observed when the Diskin's were staying at the residence of he and his wife, that the label on the rice milk product warned the product contained 0.002% barley protein and was <u>not</u> appropriate as an infant formula. Apparently, subsequently Dr. Graj canvassed this matter with Mrs. Diskin who advised him she was still breast-feeding and supplements were being added to the rice milk to give it higher nutritional value. On 16th October 2000 Nurse Haigh examined Eliana for the last time and again concluded she was progressing well. Mrs. Diskin advised Ms. Haigh she was feeding Eliana breast milk, expressed breast milk and the rice milk product. Late in October Mrs. Diskin's milk supply diminished and Eliana was weaned. Thereafter, it would appear she fed Eliana solely on rice milk to which was added two herbal additives, Life Spring Colloidal Minerals and Lifestart Original powder. At about this time, Mrs. Diskin sought advice, it would appear on a somewhat informal basis, from a Kinesiologist and a Naturopath associated with her husband's Chiropractic Clinic. What advice, if any, given is the subject of some conjecture, however, counsel for Mr. & Mrs. Diskin, Mr. Robert Richter QC formally indicated his clients seek no adverse findings against any of those who, it was earlier suggested, proffered advice which Mrs. Diskin acted upon and which persuaded her to continue Eliana on rice milk. It is significant that by the end of November Mr. & Mrs. Diskin noticed Eliana had ceased smiling and laughing and no longer made what I will describe for want of a better

expression as "baby noises". Between the 3rd to 7th of December 2000 Mrs. Diskin and Eliana travelled to Queensland to visit Mr. Diskin's family including Mr. Bernard Diskin, the father of Mr. Diskin. I refer to Mr. Bernard Diskin specifically because during an interview between Mr. & Mrs. Diskin and Julie Hall, a social worker at the Royal Children's Hospital, Mrs. Diskin conceded her father in law had expressed a view that the child appeared somewhat malnourished. It was suggested Mr. Bernard Diskin had conveyed to his son by telephone his concerns. At interview Mr. Bernard Diskin said he had no recollection of such a conversation. I am convinced, however, that conversation did occur. In the event, Mrs. Diskin said she did not act on the advice. Interestingly, at the interview with Ms. Hall, Mrs. Diskin contended that the "mistake" her and her husband made was that they consulted too widely and became "confused" by the various advice they received.

It is significant in my view that virtually all the members of the First Time Mothers Group noticed a deterioration in Eliana's condition during December; it is suggested she became pale, inactive, lethargic, quiet and appeared generally unwell, to borrow expressions by members of that group.

An interesting assessment was made of Mr. & Mrs. Diskin by Dr. Paul Campbell of the Children's Hospital Mental Health Service, who was brought in to assist Mr. & Mrs. Diskin and seek to endeavour to provide an understanding of how Eliana could become so ill in the care of her parents. His impression, contained in the last paragraph of his statement provides, I suggest, a helpful insight. Dr. Campbell opined:

> *"It is further my impression, that Mr and Mrs DISKIN are a well meaning couple, with a strong belief in non-conventional and not mainstream medical explanations for health and illness. It seems likely that their management of Eliana's illness was misguided, but with the intention of providing what they felt was the best for her. In my brief assessment I found no evidence of a major psychiatric disorder for either parent, nor suggestions of attempts to overt or covertly deliberately harm Eliana."*

On 30th October 2000, Mrs. Diskin attended with Eliana, Dr. David Soo at his practice at Ryrie Street, Geelong. The child presented with thrush at three sites, the mouth, the neck and in the area covered by the nappy. Dr. Soo said he confirmed Mrs. Diskin's understanding that Eliana's rash was thrush and advised it should clear up within a number of days, but if

it didn't to return in five days as if it didn't clear up within that time it could be a wrong diagnosis and indicative of an underlying medical condition of which the thrush was merely a symptom. Mrs. Diskin did not return. A pharmacist, Ms. Heather Lyall, said in a statement that over a period which would include November 2000 to early December 2000, Mrs. Diskin attended the pharmacy and purchased anti fungal cream for what was described as a nappy rash. Ms. Lyall says she was somewhat concerned about the amount of the cream purchased. By that I take it to mean she was concerned at the apparent persistence over this period of the rash. She concedes however, she didn't recall suggesting to Mrs. Diskin she seek medical advice.

On the 16th December 2000 at approximately 10.40pm, Eliana was conveyed to the Geelong Hospital by her parents and seen by the on duty Emergency Physician, Dr. David Eddey, after examination and investigations including :

- *"Chest X-ray*
- *Serum Urea and Electrolytes (Sodium)*
- *C-Reactive Protein (CRP)*
- *Liver Function Tests*
- *Full Blood Examination and Blood Cross Match*
- *Clotting*
- *Arterial Blood Gases."*

Dr. Eddey concluded the child, who had a widespread "weeping rash" and was patently oedematous, was critically ill and called in Dr. Christine Sanderson, Consultant Paediatrician, who took over care of Eliana. Interestingly, Dr. Eddey considered Mr and Mrs Diskin did not seem to appreciate how sick Eliana was even though they were told she was extremely ill and there was a real risk she may die. This lack of insight, which I have found impossible to comprehend, is a theme seen subsequently at the Royal Children's Hospital. That is not to say Mr. and Mrs. Diskin were unconcerned, they were. On the morning of 18th December, Eliana's condition was still a matter of grave concern to treating doctors and she was transferred to the Royal Children's Hospital where medical management was co-ordinated by Professor Andrew Kemp. Dr. Sanderson, in her statement, said she had, from the time of the initial presentation, concerns about child protection issues, but delayed making a notification to the Department of Human Services until she was satisfied there was no other illness which could have explained Eliana's

presentation apart from the inappropriate nutrition the child had been provided. However, on 21st December 2000, although she had referred Eliana on to the Royal Children's, Dr. Sanderson, after discussion with Professor Kemp, did in fact make a child protection notification to Department of Human Services. Dr. Sanderson explained the basis of her concerns in the following terms:

> *"The basis of my concerns were that Eliana had suffered significant harm as a result of inappropriate infant feeding and that there had been an unexplained delay in seeking appropriate medical attention. This led to her presentation to the Emergency Department in a critical condition."*

In the event, treating doctors at the Royal Children's concluded it highly likely Eliana's parlous condition was due to a nutritional deficiency leading to hypoalbumenemia which was subsequently complicated by systemic infection and coagulation disorder.

During the period in the Intensive Care Unit, Eliana's condition remained dire. She developed renal failure which required haemofiltration, septic shock which required high dose inotropes and continuing mechanical ventilation. She was also treated with antibiotics, anti fungal agents and immunoglobulin together with ongoing internal support intravenously.

The apparent failure, founded on what I do not know, to appreciate the grave condition of Eliana is again manifested by discussions between hospital social worker Julie Hall initially with Mrs. Diskin and subsequently with Mr. Diskin on 25th December. Mrs. Diskin told Ms. Hall how her husband had conducted a "muscle test" the previous evening and based on that test concluded Eliana would be fully recovered within two weeks. Mr. Diskin confirmed that matter with Ms. Hall later that evening and re-confirmed his belief that in conjunction with medical treatment an energy balancing technique with which he had been treating Eliana was contributing to her physical healing. Regrettably, on 26th December 2000, Eliana passed away.

Mr and Mrs. Diskin were interviewed by Homicide Squad detectives and subsequently charged with manslaughter. At the conclusion of a contested committal proceeding both Mr. and Mrs. Diskin were discharged, the presiding magistrate concluding a properly instructed jury could not, on the evidence, find the parents guilty of the level of gross negligence to warrant criminal sanctions. It is not appropriate for me to

make comment on the bases the learned magistrate came to the conclusions she did, nor do I seek to, I merely refer to a non-core observation she made and indicate I agree with it. The magistrate (at P.9 of her Reasons for Decision) stated :

> *"There was too much disparate advice accepted at face value by the parents with ill-founded confidence."*

The functions of the magistrate and myself are not only separate and distinct, but also very different.

The Coroners Act 1985, Section 19(1)(a)-(c) provides the core findings a coroner must (if possible) make. They include findings of ?how the death occurred? (Section 19(1)(b)) and the ?cause of death? (Section 19(1)(c)). Sub-section (2) of Section 19 provides a coroner may also ?comment on any matter connected with the death.

In Keown v Khan (1999) VR 69 (Court of Appeal) Mr. Justice Callaway in the leading judgement of the court, undertook a thorough review of the coronial function. In my view, his judgement re-focused coroners upon the true nature of their task. His Honour made reference to the report handed down by Sir John Norris QC (The Norris Report) upon which the Coroners Act 1985 is substantially founded and observed @ p.76 of his judgement :

> ?*"In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame: the proceeding is inquisitorial; the conclusion would be more indeterminate than a conclusion about legal responsibility; and there would be no prospect of a trial at which the person blamed might ultimately be vindicated by an acquittal.?"* (My emphasis)

The coroner's responsibility is to investigate the circumstances of the death; find the facts (as best one can) set out the facts in a formal finding; the facts then speak for themselves leaving others to apportion blame or responsibility, draw legal conclusions and make judgements.

The Broderick Committee (UK) (para 16.40) observed:

> *?"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceedings which affords to others the opportunity to judge on issues and one which appears to judge the issue itself.?"*

With the repeal of paragraph (e) of sub-section 1 of Section 19 of the Coroners Act 1985 it is only as to cause of death that an enquiry as to culpability is mandated. If an act or omission was the cause, or one of the causes, of a death that formal finding should be made by a coroner. Again in Keown v Khan (1999) VR 69 @ p.69, Ormiston, J.A., said:

> *?"The findings of coroners ought to eschew use of language which connotes legal conclusions as opposed to factual findings."?*

As the matter had the potential for quite a protracted hearing, I listed it for mention with a view to endeavouring to establish whether Mr and Mrs Diskin were seeking adverse findings against those they blamed in their respective records of interview with police including the Geelong Hospital, the Royal Children's Hospital, Child and Maternal Health Nurse Haigh, and various others from whom they claim to have sought advice and guidance including medical doctors, a naturopath, a kinesiologist and others. I was endeavouring to identify and isolate the issues and fix the parameters and scope of the coronial hearing, the inquest, seek to establish who would be "interested parties" and to gauge how much sitting time would need to be set aside for the hearing.

In the event, Mr. Richter formally indicated that his clients would not be seeking adverse findings against anyone and were conceding Eliana's death was due to complications arising from malnutrition caused, inadvertently by feeding the infant child after she was weaned solely on rice milk with supplements, an entirely inappropriate and inadequate infant nutrition. I was not entirely sure whether Mr. Richter, on behalf of Mr. & Mrs. Diskin, formally conceded their acts and omissions were the cause of Eliana's death. That is the principle issue I have to consider.

In March v E and M.H. Stamare Pty Ltd (1991) 171 CLR 506 @ p.522 Deane J., observed:

> *"the question of causation arises in the context of attribution of fault or responsibility whether an identified negligent act or omission of the defendant was so connected with the plaintiff's loss of injury that, as a matter of ordinary common sense and experience, it should be regarded as a cause of it."*

It has been suggested this test is too vague and imprecise giving little practical assistance to coroners in determining whether a particular circumstance, or factual matrix, should be regarded as causative. It is very much a judgement call, but rendered manageable by the application of the appropriate standard of proof the test referred to as the "Briginshaw Test" (see Briginshaw v Briginshaw (1938) 60 CLR 336; to make a finding a parent, or parents, actually caused the death of their child, a quite high standard must be applied, such a finding should not be made on inexact proofs, indefinite testimony or indirect inferences, but only on cogent and persuasive proofs; a comfortable degree of satisfaction must be reached to conclude an act or omission caused a death, (Anderson v Blashki (1993) 2 VR 89; Health and Community Services v Gurvich (1995) 2 VR 69 and Chief Commissioner of Police v Hallenstein (1996) 2 VR 1).

I formally find Mr. Marcus and Mrs. Ora Diskin did indeed cause the death of Eliana. In breach of a fundamental duty of care they failed to ensure their infant child was adequately nourished resulting in severe protein energy malnutrition a deficiency resulting in disseminated candidiasis. The other basis upon which, in combination, Mr. and Mrs. Diskin were in breach of their duty of care to baby Eliana was the inordinate delay in seeking an appropriate medical attention after it became, or should have become clear that due to her perilous condition, Eliana required specialist medical treatment. Eliana's death represents, from any perspective, a tragedy almost beyond comprehension.

In the circumstances, Mr. Richter submitted, there was no public utility in a further formal inquest hearing and a finding could be made "on the papers", that is the material in the brief. It could well be argued there is a public interest in running an inquest with a view to publicising the dangers associated with feeding infants products which are inappropriate, the issue of adequacy of warnings on product packaging, perhaps even the

issue of the accepting advice on something as critical as infant nutrition from those without the necessary expertise to proffer such advice.

However, on reflection those issues were either implicitly or explicitly widely aired during the fourteen day committal hearing before Magistrate Barbara Cotterell and in any event it is not appropriate to run a formal inquest for the sole or dominant purpose of comment or recommendation; the coroner's prime function is to make findings particularly the core findings required by S.19(1) of the Coroners Act 1985. (See Harmsworth v State Coroner (1989) VR 989). Furthermore, my finding, albeit made "on the papers", becomes a public document and available to the press, or any other interested party, using the term in a broad, not the narrow coronial sense.

I only add in relation to the adequacy of the warning on the product packaging the subject of this matter, the product package bore the following statement : "Not recommended (or suitable) for infant feeding" and further stated the product contained a very small percentage of protein. Whilst the warning could be in more explicit even absolute terms, the message, in my view, is clear and the subject matter so innately vital that a parent proposing to feed an infant child exclusively on the product is forewarned of the inappropriateness of doing so.

In conclusion I adopt and commend a further observation made by Magistrate Cotterell; she commented:-

> *"I also hope the publicity surrounding this case will alert parents, and all health professionals, of the dangers of feeding alternative substances to infants without the supervision or advice of a qualified paediatrician or expert in the field of infant nutrition."*

PHILLIP BYRNE
CORONER