Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 48/ 15

I, Barry Paul King, Coroner, having investigated the death of ***T R N (name suppressed)*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***30 November 2015****, find that the identity of the deceased person was* ***T R N (name suppressed)*** *and that death occurred on* ***31 December 2010*** *at* ***Redcliffe*** *from* ***an unascertained cause*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisting the Coroner
Ms J C O'Meara (State Solicitor's Office) appearing for the Department of Child Protection and Family Support

Table of Contents

SUPPRESSION ORDER

The identity of the deceased, the deceased's parents, the deceased's foster carers and the foster carers' family, including the 18 year old boarder, and any detail that could lead to identifying any of those persons, not be published.

INTRODUCTION

1. T R N (**the deceased**) died suddenly on 31 December 2010 while lying in her cot. She was two years old.

2. As the deceased was a person in the care of the CEO as defined in section 3 of the *Children and Community Services Act 2004* at the time of her death, she was a 'person held in care' under section 3 of the *Coroners Act 1996*.

3. Section 22 (1)(a) of the *Coroners Act 1996* provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

4. An inquest was therefore mandatory. Accordingly, I held an inquest on 30 November 2015 in the Perth Coroners Court.

5. I was unable to determine the cause of death.

6. Under s25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

7. I have found that the supervision, treatment and care of the deceased was reasonable and appropriate.

THE DECEASED

8. The deceased was born in Swan District Hospital on 15 July 2008 by spontaneous vaginal delivery after 37 weeks and five days gestation. At birth she was given antibiotics for suspected Group B strep infection and a raised CRP.[1]

[1] Exhibit 1, Tab 13

9. Due to concerns about the deceased's parents' ability to care for her, on 28 July 2008 officers of the Department for Child Protection (**the DCP**) took the deceased into provisional protection and care and placed her with foster carers (**the foster carers**).[2] On 23 September 2008, by consent the Children's Court of Western Australia ordered that the CEO of the DCP have parental responsibility for the deceased for two years.[3]

10. When the deceased went to the foster carers, she thrived and met all her developmental milestones. She was a healthy, happy and alert child with an abundance of energy.

11. The deceased formed strong attachments with her foster carers and her foster siblings, who clearly loved her. She also attended contact visits with her parents and her biological siblings, so maintained a bond with them.[4]

12. While the deceased's health was generally good, she had experienced three minor seizures, which were attributed to teething or a raised temperature. They each lasted less than a minute and had no ongoing effect. The last episode was on 17 October 2010.[5]

THE DECEASED'S FOSTER CARERS

13. The female foster carer was a registered nurse and the male foster carer was a teacher at a private school in the Perth area. They lived in Redcliffe with their 18 year old and five year old daughters. Also living with them was their eldest daughter's friend (**the boarder**), who considered them to be like step-parents. She shared a bedroom with the deceased.[6]

[2] Exhibit 1, Tab 28
[3] Exhibit 1, Tab 16
[4] Exhibit 1, Tab 28
[5] Exhibit 1, Tab 28
[6] Exhibit 1, Tab 10

14. The foster carers had been foster carers for another child for five months commencing in 2007 and provided respite and emergency placements for the DCP. In late August 2008 they took on the care of another little girl who was eight months older than the deceased. They continued to provide respite placements while looking after the two little girls.[7]

15. During the time the deceased was placed with the foster carers, DCP officers conducted regular reviews of her care. The reports resulting from the reviews indicated that the deceased was happy and generally healthy. There was some tension between one case manager and the foster carers, but the DCP did not have any concerns in relation to the standard of care provided to the deceased.[8]

16. At the time of the deceased's death, the DCP was in the process of extending her protection order. A DCP officer had spoken to the foster carers to ask if they were willing to care for the deceased in the long term. They indicated that they were more than willing to do so as they considered her to be family.[9]

17. In a letter sent by email to Sergeant Housiaux after the inquest on 14 December 2015, the foster carers stated:

> (The deceased's) death still affects us today as a family. She was the most vibrant, active, fun loving girl in our house. She rarely walked when she could be running, jumping or skipping. Her joy of life was huge and hence made it so for all of us. Our youngest daughter in particular, who has just turned 9 still misses both her younger sisters enormously. As do we all. We loved (the deceased) dearly and that love was not

[7] Exhibit 1, Tab 28
[8] Exhibit 1, Tab 28
[9] Exhibit 1, Tab 25

different to the love we had for our own girls.

CONCERNS OF THE DECEASED'S PARENTS

18. The deceased's parents made several complaints to the DCP about the standard of care provided to the deceased by the foster carers and others involved in her care.[10]

19. In particular, the deceased's parents expressed concerns about:

    a) an apparent black eye the deceased had on 24 August 2009;

    b) the need to confront DCP staff on 16 October 2009 in order for the deceased to be taken to a doctor in relation to a rash on her face and a sore on her left thigh;

    c) an apparent burn on the deceased's hand from a hot iron;

    d) an injury to the deceased's finger from being jammed in a door in December 2009; and

    e) the foster carers' failure to take the deceased to see a doctor after having seizures.

20. In my view, the evidence makes clear that there were reasonable explanations for each of the deceased's parents' concerns:

    a) In relation to the apparent black eye, the female foster carer took the deceased to the emergency department of Princess Margaret Hospital (**PMH**) on 23 August 2009 with a swollen eye. She had tried applying a cold compress and eye drops with no

[10] Exhibit 1, Tabs 11 and 26

effect. She told emergency staff that the deceased had a seizure while playing when she had a raised temperature. She had called an ambulance but the deceased recovered fully so was not seen by a doctor.[11]

The PMH staff examined the deceased and gained the impression that the deceased had a viral or allergic reaction. She was discharged home with advice to see a doctor the next day.[12]

b) As to the events of 16 October 2009, the evidence indicates that they actually took place on 12 October 2009 during a contact visit that the deceased's parents had with the deceased at the DCP office. The deceased had a right eye infection and a rash on her upper left thigh.

After an acrimonious confrontation between the parents and DCP staff requiring the attendance of police officers, DCP officers took the deceased to a doctor in Cannington.[13] The doctor diagnosed a viral infection called slapped face syndrome and a bacterial infection known as school sores (impetigo) on the thigh. He prescribed paracetamol for the fever and an antibiotic ointment for the school sores. The deceased saw the doctor again on 15 October 2009, at which time she was much improved.[14]

The female foster carer said that she had noticed the sore, which she believed had been picked up from day-care. She had been treating it with an anti-fungal cream. She believed that the deceased's nappy was rubbing against it, making appear worse than it was.[15]

[11] Exhibit 1, Tab 12
[12] Exhibit 1, Tab 12
[13] Exhibit 1, Tab 26
[14] Exhibit 1, Tab 14
[15] Exhibit 1, Tab 9

c) As to the burn from an iron, the deceased's father had noticed blisters on the deceased's hand during a contact visit on 21 September 2009. When asked about it, the female foster carer said that, while she was ironing, the deceased had pulled on the iron cord and grabbed the iron. This was an accident for which she took responsibility.[16]

d) As to the injury to the deceased's finger, the evidence indicates that the deceased was playing with her foster siblings when the two year old foster child slammed a door on her finger.[17] She was admitted to PMH on 12 December 2009 and underwent repair of the finger nail bed on the next day. There were no complications and no physical impairment.[18] A duty of care assessment by DCP staff on 21 December 2009 noted that the deceased was using her hand without any discernible discomfort and that her general high level of activity and her tendency to climb objects around the house indicated that she had been largely unchanged by the event.[19]

e) As to the foster carers not taking the deceased to see doctors after she experienced febrile seizures, the DCP records show that the foster carers notified the DCP about the seizures.[20]

They did not take the deceased to see a doctor because in each case the seizure lasted for less than a minute and was related to a cold or a raised temperature. The other young foster child experienced three prolonged seizures prior to the deceased's seizures. In each case the child was taken by ambulance to PMH where she was monitored for a few hours and sent home with no follow up.[21]

[16] Exhibit 1, Tab 26
[17] Exhibit 1, Tab 26
[18] Exhibit 1, Tab 12
[19] Exhibit 1, Tab 26
[20] Exhibit 1, Tab 26
[21] Email letter of 14 December 2015

In the deceased's case, the female foster carer, as a registered nurse, considered that the deceased was experiencing febrile seizures that did not require further investigation.[22]

21. In these circumstances, I am satisfied that the concerns held by the deceased's parents were well-intentioned but, on examination, were without actual foundation.

EVENTS LEADING UP TO THE DEATH

21. On 30 December 2010 the deceased was her usual energetic self. It was a hot summer day and the deceased had been in the backyard pool with the family for much of the afternoon.[23]

22. Nothing unusual had occurred that afternoon but, after a dinner of stir-fry, the female foster carer noticed that the deceased had a temperature, so she gave her a child dosage of paracetamol and placed her in her cot.[24]

23. At about 9.15 pm the male foster carer picked up the boarder and brought her home from her work at Belmont Forum. She had a shower and some dinner and, at about 10.00 pm, she went to bed in the room she shared with the deceased. The deceased pushed herself up to look at her and told her that she loved her. The boarder told her that she loved her more. At that, the deceased lay back down and went back to sleep.[25]

24. At about 2.00 am on 31 December 2010 the female foster carer got up to check on the girls as she did normally. She touched the deceased's leg and felt that her temperature had come down, so she covered her legs with a blanket. She was going to let the deceased

[22] Exhibit 1, Tab 26 and Email letter of 14 December 2015
[23] Exhibit 1, Tab 9
[24] Exhibit 1, Tab 9
[25] Exhibit 1, Tab 10

sleep late that morning because she had been so active on the previous day.[26]

25. In the early hours of the morning the boarder awoke briefly and heard the deceased talking softly to herself in her sleep as she often did.[27]

26. The boarder awoke again briefly at 7.30 am when her alarm went off. She could not hear anything in the room. She looked over at the deceased who appeared to be sleeping face down.[28]

27. When the boarder finally awoke at about 8.15 am, she got up to get ready for work and noticed that the deceased was facing straight down with her arms straight by her side and that she was pale white and had blue patches all over her body. The boarder ran into the study to alert the female foster carer who was using the computer.[29] They both then went to the deceased and the female foster carer determined that the deceased had no pulse.[30]

28. The female foster carer took the deceased to the main bedroom floor and commenced cardiopulmonary resuscitation while the male foster carer spoke to St John Ambulance by phone.[31]

29. Ambulance officers arrived within 10 minutes, but the deceased showed no signs of life and appeared to have been dead for some time.[32]

CAUSE OF DEATH AND HOW DEATH OCCURRED

30. Forensic pathologist Dr D M Moss conducted a post-mortem examination of the deceased on 5 January 2011. He found no evidence of injury or natural disease

[26] Exhibit 1, Tab 9
[27] Exhibit 1, Tab 10
[28] Exhibit 1, Tab 10
[29] Exhibit 1, Tab 10
[30] Exhibit 1, Tab 9
[31] Exhibit 1, Tab 9
[32] Exhibit 1, Tab 15

to account for death, so extensive further investigations were carried out.[33]

31. Extensive microscopy of the organs and tissues was performed and Dr G Jevon, a consultant paediatric and neonatal pathologist at PMH, assisted by reviewing slides of samples. The histology showed mild congestion and oedema in the lungs with mild lymphocytic tracheitis, bronchitis and bronchiolitis. There was no evidence of epithelial necrosis, pneumonia, syncytial giant cells or viral inclusions. There was a focal collection of lymphocytes in the right side of the heart but no features of myocarditis. There was evidence of *Enterobius vermicularis* in the appendix but no significant associated inflammation. The rest of the tissues and organs appeared normal.[34]

32. Macroscopic neuropathological examination of the brain showed cerebral swelling and congestion of the leptomeningeal vessels and no other abnormality. Microscopic examination of the brain showed no significant abnormality.[35]

33. Toxicological analysis showed a low level of paracetamol and no other notable findings.[36]

34. Extensive virological and microbiological testing was undertaken. Several viruses were detected in several tissues, including the respiratory tract, but microbiological samples showed no pathogenic bacteria in the lungs. Dr Jevon advised that the viruses indicated previous latent or intercurrent infection which he could not relate to the cause of death in the absence of significant inflammation in the heart or lungs. He noted that there was no evidence of an underlying metabolic disorder which might predispose to death during a mild intercurrent infection.[37]

[33] Exhibit 1, Tab 7
[34] Exhibit 1, Tab 7
[35] Exhibit 1, Tab 7
[36] Exhibit 1, Tabs 7 and 8
[37] Exhibit 1, Tab 7

35. Dr Moss concluded in his report that in his opinion the cause of death was best given as 'unascertained',[38] which I adopt.

36. Dr Moss went on to mention that the deceased's case likely meets the criteria for inclusion in a nationwide cardiac genetic testing study.[39]

37. Dr Moss said in oral evidence that issues arose with having the deceased included in the nationwide study but a laboratory in Perth was able to do the genetic analysis. The laboratory found no clinically relevant genetic sequence variants, so a mutation that is currently known to cause disease was not detected.[40]

38. Dr Moss said that he will obtain lists from the laboratory relating to what was tested for and what was found, so that he could pass that information to a cardiologist in Melbourne who is currently reviewing the deceased's brother (born in April 2012) for potential cardiac problems that may have been inherited from their father. Dr Moss said that he did not know how long it might take to eventually learn from the cardiologist whether there is anything relevant in the laboratory's results.[41]

39. As to the issue of how death occurred, the deceased was at an age such that there is no likelihood that her sleeping position would have contributed to her death.

40. On the basis of the foregoing, I find that death occurred by way of natural causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

41. In the circumstances described above, I am satisfied that the quality of supervision, treatment and care of

[38] Exhibit 1, Tab 7
[39] Exhibit 1, Tab 7
[40] ts 18 per Moss, D M
[41] ts 18 per Moss, D M

the deceased by the foster carers under the supervision of the DCP was reasonable and appropriate.

CONCLUSION

42. The deceased was two years of age and full of life and joy when she died unexpectedly and without any apparent cause.

43. I regret that the distress which her death has caused her parents and her foster carers has been compounded by the fact that I am not able to find the cause of her death. I can but hope that future advancements in medical science will provide both an explanation for why she died and the means of preventing other infants from dying in a similar way.

B P King
Coroner
11 March 2016