JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Philip John Urquhart, Coroner
HEARD	**:**	20 JULY 2021
DELIVERED	**:**	13 AUGUST 2021
PUBLISHED	**:**	26 AUGUST 2021
FILE NO/S	**:**	CORC 156 of 2020
DECEASED	**:**	Baby E

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Counsel	:	Rhela Belton
Counsel Assisting	:	William STOPS
Counsel	:	Eloise Langoulant
Counsel Assisting	:	Madeline JAMES
Counsel	:	Jessica Berry

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Philip John Urquhart, Coroner, having investigated the death of a male child referred to as **Baby E** with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 20 July 2021, find that the death of **Baby E** occurred on 1 February 2020 at Rockingham General Hospital, Cooloongup, from complications of VATER syndrome and sacrococcygeal teratoma in the following circumstances:*

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SUPPRESSION ORDER

Suppression of the deceased's name from publication and evidence likely to lead to the child's identification.

The deceased is to be referred to as 'Baby E'.

INTRODUCTION

1 The deceased (Baby E) died on 1 February 2020 from complications of VATER syndrome[1] and sacrococcygeal teratoma.[2] He was exactly seven months old.

2 At the time of his death, Baby E was in the care of the Chief Executive Office (CEO) of the Department of Communities (the Department).

3 Accordingly, immediately before his death, Baby E was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) and his death was therefore a "*reportable death*".[3]

4 In such circumstances, a coronial inquest is mandatory.[4] Where, as here, the death is of a person held in care, I am required to comment on the supervision, treatment and care the person received from the Department whilst in that care.[5]

5 I held an inquest into Baby E's death at Perth on 20 July 2021. The following witnesses gave oral evidence:

i) Dr Nicholas Larkins (Paediatric Nephrologist, Perth Children's Hospital); and

ii) Mr Andrew Geddes (Regional Executive Director, South Metropolitan Region with the Department).

[1] VATER syndrome refers to several birth defects that frequently occur in conjunction with one another. The letters stand for the areas of the body impacted by these defects: vertebrae, anus, trachea, esophagus and renal.
[2] A tumour that develops before birth and grows from the baby's coccyx (i.e. tailbone).
[3] Section 3, *Coroners Act 1996* (WA)
[4] Section 22(1)(a), *Coroners Act 1996* (WA)
[5] Section 25(3), *Coroners Act 1996* (WA)

6 The documentary evidence at the inquest comprised of one volume, which was tendered as Exhibit 1. An additional exhibit was provided by the Department after the inquest and it became Exhibit 2.

7 The inquest focused on the involvement of the Department in Baby E's life and on the management of his medical conditions by various hospitals.

8 On the basis that it would be contrary to public interest, the State Coroner made a suppression order with respect to Baby E's name on 5 March 2021, pursuant to section 49(1) of the *Coroners Act 1996* (WA). The terms of that order are set out on page 3 of this finding.

BABY E'S MEDICAL ISSUES [6]

Background

9 Baby E was born on 1 July 2019 at 30 weeks and 6 days gestation by emergency caesarean section at King Edward Memorial Hospital (KEMH). He required resuscitation, intubation, and ventilation at birth. His birth weight was 1,480 grams.

10 The pregnancy of Baby E's mother was complicated by her on-going use of cannabis and methylamphetamine. She developed oligohydramnios (decreased amount of fluid around the baby) and an ultrasound revealed the baby had intrauterine growth retardation, an absent left kidney, and right renal hydronephrosis (a swelling of the kidney).

Diagnosis

11 Shortly after his birth, Baby E was diagnosed with hyaline membrane disease and apnoea of prematurity. He was administered surfactant, caffeine, and supplementary oxygen. In addition to having no left kidney, Baby E had an absent anus (imperforate anus) and multiple skeletal abnormalities. He also required antibiotics to treat a suspected infection.

12 On 2 July 2019, Baby E was transferred to the neonatal intensive care unit at Perth Children's Hospital (PCH) for urgent bowel and kidney surgery. He subsequently remained at PCH for over 5 months.

[6] Exhibit 1, Volume 1, Tab 11, King Edward Memorial Hospital Discharge Summary; Exhibit 1, Volume 1, Tab 16, Report by Dr Lindsay Adams dated 20 February 2020; Exhibit 1, Volume 1, Tab 17, Report by Dr Nicholas Larkins dated 30 March 2020; Perth Children's Hospital Medical Records (5 volumes)

13 Baby E had a very complex medical history. He was not only diagnosed with VATER syndrome, but he also suffered multiple medical conditions during his short life, which are listed below:

- Imperforate anus requiring colostomy
- Vertebral anomalies comprising of cervicothoracic and lumbar scoliosis, T1 and T2 vertebral fusion, T3 hemivertebrae and sacral hemivertebrae
- Unilateral agenesis of left kidney and dysplasia of right kidney
- Right hydroureter (dilatation of ureter)
- Neonatal hypertension
- Neonatal pulmonary haemorrhage
- Hypothyroidism
- Patent ductus arteriosus
- Jaundice of prematurity
- Anaemia
- Thrombocytopaenia (low platelet count)
- Sacrococcygeal teratoma, which impinged upon the spinal cord
- Chronic kidney disease – Stage 5
- Renal osteodystrophy/rickets (bone disease associated with chronic renal disease)
- Renal-induced hypertension and associated left ventricular hypotrophy
- Ascites secondary to renal failure
- Chronic lung disease
- Recurrent lower respiratory tract infections
- Bilateral inguinal hernias
- Fractures to the right radius and humerus
- Seizures
- Infected long line tube
- Prolapsed stoma
- Candida UTI (urinary tract infection)
- Right-sided abdominal incisional hernia

14 There were many clinicians and allied health professionals involved in Baby E's care. They included renal physicians, respiratory physicians, neurosurgeons, neurologists, endocrinologists, haematologists, oncologists, radiologists, general surgeons, urologists, cardiologists, and infectious disease specialists.

15 Between 3 July 2019 and 9 October 2019, Baby E underwent surgery on six occasions.

Over-view of main health conditions

16 Baby E developed chronic renal failure with associated osteodystrophy and anaemia. He required supplements for his bone health, regular injections of erythropoietin to increase his red-blood cell production and iron infusions to manage his iron deficiencies. He was fed six times a day through a nasogastric tube. He suffered repeated episodes of aspiration and was prescribed regular antibiotics to prevent chest infections. His imperforate anus required a colostomy operation. The sacrococcygeal teratoma (tumour) on his lower spine was found to be progressively enlarging, causing significant pressure on his spinal cord. That resulted in an apparent leg length discrepancy, with his left leg being shorter than his right. These conditions would have ultimately required neurosurgery and extensive pelvic surgery.

17 Baby E's kidney function continued to deteriorate over time, to the extent that he was going to require kidney replacement therapy to prolong his life. However, the three main forms of therapy were either not immediately available or viable. The first option was to have a kidney transplant. However, this required the recipient to weigh at least 10 kg and it would have taken Baby E at least two to three years to achieve that weight.[7] The second option was peritoneal dialysis. However, that was not viable as Baby E's abdomen required multiple other surgeries and, given his size, it was unlikely to be successful.[8] The third option was haemodialysis, which Baby E was unable to receive at PCH due to his age and small size.[9]

18 Baby E's multiple medical conditions had a substantial impact on his current and future potential quality of life. After discussions between Baby E's multi-disciplinary hospital team, his family and Department staff, a decision was made not to pursue dialysis, given the high expected mortality and morbidity. A referral was made to PCH's Palliative Care Team and the main aim of treatment from December 2019 was to enable Baby E to spend time at home with his family before his death.

19 On 24 December 2019, Baby E was discharged from PCH into the care of his maternal grandmother, who was a qualified nurse (the grandmother).

[7] ts 20.7.21 (Dr Larkins), p.13
[8] ts 20.7.21 (Dr Larkins), p.13
[9] The smallest child who has been haemodialysed at PCH weighed seven kg: ts 20.7.21 (Dr Larkins), p.13

EVENTS LEADING UP TO DEATH [10]

20 On 31 January 2020, the grandmother noticed that Baby E had intermittent difficulty in breathing and episodes of twitching. At 11:30 pm, he started screaming during his nasogastric tube feed. Although he vomited, Baby E then appeared to settle and went back to sleep.

21 At about 3:30 am on 1 February 2020, Baby E woke up and had another feed before he started to scream again. He eventually settled and began sleeping.

22 When Baby E woke up at 6:00 am, the grandmother could feel a solid mass on the right-side of his abdomen. She then made plans to take him to hospital.[11] However, as she was leaving the house, Baby E suddenly became limp and unresponsive and so she called an ambulance. That call was made at 6:57 am.

23 The ambulance arrived at 7:07 am, as the grandmother was actively giving Baby E Expressed Air Resuscitation (EAR). When they examined Baby E, ambulance officers noted his airway was patent and that he was limp and mottled, with a fixed gaze. He was using his accessory muscles to breathe and was intermittently groaning. Baby E's abdomen was distended on the right side. He was administered oxygen and taken to Rockingham Hospital, arriving at 7:26 am.

24 At Rockingham Hospital, Baby E was diagnosed with "acute gut catastrophe". He was given intranasal fentanyl and intramuscular midazolam, to keep him comfortable. Baby E died in the grandmother's arms at 8:30 am.

CAUSE AND MANNER OF DEATH [12]

25 Dr Daniel Moss, a forensic pathologist, conducted an external post mortem examination on Baby E's body, following an objection to an internal post mortem examination being made by Baby E's family. That external examination took place on 4 February 2020. The examination showed evidence of previous abdominal surgery, including a colostomy. There was no external evidence of any significant injury.

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[10] Exhibit 1, Volume 1, Tab 10, Statement – Baby E's grandmother dated 27 April 2020; Exhibit 1, Volume 1, Tab 18, St John Ambulance Patient Care Records

[11] This included making arrangements for someone to look after her three other grandchildren who were also in her care.

[12] Exhibit 1, Volume 1, Tab 5, Post Mortem Report by Dr D. M. Moss dated 4 February 2020

26 At the conclusion of his investigations, and after a review of the PCH medical file for Baby E, Dr Moss expressed the opinion that the cause of death was complications of VATER syndrome and sacrococcygeal teratoma.

27 I accept and adopt the conclusion expressed by Dr Moss as to the cause of Baby E's death.

28 I find that the death occurred by way of natural causes.

THE STANDARD OF BABY E'S MEDICAL CARE

29 It is without doubt that the vast array of Baby E's medical conditions was extremely complicated and complex. Although Dr Larkins noted in his evidence that each one of Baby E's medical problems individually were treatable, "*the constellation of them to treat …* [meant] *his mortality would have been in excess of 80-90%, and if he did live, the process of getting there would have been difficult.*"[13]

30 I fully agree with Dr Larkin's assessment that the decision to treat Baby E palliatively at home, once his lungs had stabilised, was "*the kindest thing to do*".[14]

31 Having reviewed the evidence in this case, I am satisfied Baby E received quality medical treatment at PCH from dedicated and committed hospital staff. He received input from a multitude of surgical, medical, and allied health specialists and every effort was made to provide him with the best quality of life given the very difficult circumstances. These comments also extend to the medical treatment at KEMH and at Rockingham Hospital for the short duration he was in the care of these hospitals.

THE DEPARTMENT'S INVOLVEMENT WITH BABY E

Contact with the Department by Baby E's family before his birth [15]

32 Baby E had three older siblings, the eldest being five years old when Baby E was born. Between 2013 and 2018, the Department completed a total of 19 Safety and Wellbeing Assessments (SWA) in relation to Baby E's siblings.

[13] ts 20.7.21 (Dr Larkins), p.14
[14] ts 20.7.21 (Dr Larkins), p.15
[15] Exhibit 1, Volume 1, Tab 15, Report by Jackie Tang (Assistant Director General of the Department of Communities) dated 4 August 2020

These SWAs related to various issues, including the mother's methylamphetamine use and mental health concerns and exposure to family domestic violence. On three occasions, the Rockingham District office of the Department substantiated harm, or likelihood of harm, to the children.

33 On 2 August 2018, the Department placed Baby E's siblings into provisional protection and care, pursuant to section 35 of the *Children and Community Services Act 2004* (WA) (the Act). The Department placed the three children into the care of the grandmother. On 16 August 2018, the grandmother was approved as a family carer by the Department, pursuant to section 79(2)(b) of the Act.

34 On 19 December 2018, Perth Children's Court granted the Department's application for protection orders of two years duration.

35 On 6 February 2019, the Department approved the grandmother as a relative carer, under regulation 4 of the *Children and Community Services Regulations 2004* (WA).

Provisional protection and care of Baby E [16]

36 Baby E's mother had a long history of illicit drug use and, despite multiple referrals to support services over the years, efforts at rehabilitation failed. She was known to Rockingham Kwinana Mental Health Service (RKMHS) and had been diagnosed with drug-induced psychosis.

37 On 8 March 2019, RKMHS notified the Department that the mother was 14 weeks pregnant with Baby E and that she had been injecting methylamphetamine weekly.

38 On 12 March 2019, the Department completed an intake to a SWA to assess neglect concerns for the mother's unborn child and to commence pre-birth planning.

39 On 7 May 2019, the Department held the first Pre-Birth Planning meeting. At that meeting, the mother agreed to attend a residential rehabilitation program operated by Cyrenian House. Although the mother was admitted to the program on 29 May 2019, she left three days later.

[16] Exhibit 1, Volume 1, Tab 15, Report by Jackie Tang (Assistant Director General of the Department of Communities) dated 4 August 2020

40 On 11 June 2019, a second Pre-Birth Planning meeting was held. The Department informed the mother that she would need to enter residential rehabilitation immediately after the birth to assess whether it was suitable for her child to remain in her care. The mother agreed to undertake an assessment regarding her suitability to enter into a residential rehabilitation program. This assessment was arranged for 1 July 2019. However, the assessment never took place as Baby E was born on that date.

41 On 2 July 2019, a social work coordinator at KEMH informed the Department that Baby E's mother had disclosed she no longer wanted to engage in residential rehabilitation and was proposing a move to Esperance to reside with her partner.

42 On 8 July 2019, the Department brought Baby E into the provisional protection and care of its CEO, pursuant to section 35 of the Act.[17] The basis of this decision was that Baby E would be at an unacceptable risk of harm if discharged into his mother's care, due to her illicit drug use and the impact of this use on her parental capacity and mental health.

43 Although there was an initial hope that Baby E could be discharged from PCH after three weeks, complications arising from his numerous medical conditions meant that he remained an in-patient at PCH until 24 December 2019. During that time the Department provided consents for medical treatments and investigations in line with medical advice.

44 On 10 July 2019, an application was filed by the Department in Perth Children's Court for a protection order of two years duration for Baby E.

45 On 19 July 2019, PCH advised the Department that Baby E had become very unwell at approximately 1:00 am, due to a catastrophic pulmonary haemorrhage and had to be re-ventilated. He was in a serious condition and receiving maximum support to sustain his life.

46 On 24 July 2019, the Department completed the SWA that had commenced with the intake on 12 March 2019. The SWA noted that Baby E's mother did not appear to have the capacity to meet his anticipated high medical needs, or to protect him from harm due to her fluctuating mental health and drug

[17] The Act does not permit the CEO of the Department to take into care an unborn child: ts 20.7.21 (Geddes), p.23

dependency. The Department was satisfied that Baby E was likely to suffer harm in his mother's care due to her unstable mental health, her non-compliance with medication and on-going illicit drug use, which was contributing to her psychotic episodes. On that same day, Baby E's mother completed urinalysis, which was later found to be positive for methylamphetamine.

47 On 7 August 2019, RKMHS notified the Department that Baby E's mother did not attend an appointment two days earlier and that the perinatal health team at RKMHS was reluctant to continue to work with Baby E's mother due to her on-going drug use.

48 On 12 August 2019, staff from the Department conducted an unannounced home visit to Baby E's mother. During that visit, she disclosed on-going methylamphetamine use to cope with her current distress.

49 In August 2019, the Department commenced an assessment of the grandmother's suitability to care for Baby E. Over the following months, the grandmother visited Baby E at PCH every two to three days.

50 Regular multi-disciplinary meetings were conducted at PCH with the Department in attendance. At one such meeting on 29 November 2019, medical staff discussed Baby E's on-going health concerns, including dialysis requirements, stoma care needs, respiratory concerns, vertebral anomalies and increased sacral mass. The Department informed PCH that the grandmother's care assessment for Baby E was being finalised and pending approval. On this same day, the Department was advised by the neurosurgical service at PCH that Baby E had a spinal tumour that was progressively enlarging and causing significant compression of his spinal cord.

51 On 9 December 2019, the Department finalised the grandmother's review and recommended that she be approved to care for four children, thereby enabling her to care for Baby E.

52 On 13 December 2019, another multi-disciplinary meeting took place at PCH. This was attended by Department staff and the grandmother.

53 On 16 December 2019, the Department received an email from Dr Larkins, advising that rather than proceeding with invasive surgery on Baby E's pelvis and spine, the medical plan going forward was to take a more conservative

approach. The email also confirmed that Baby E's family did not want him to receive dialysis and that a referral had been made to the Palliative Care Team to commence planning to get Baby E home in a timely manner, with appropriate supports. Dr Larkins also advised the likely outcome was that Baby E would pass away in the next few months.

54 On 18 December 2019, Baby E's mother informed Department staff that she agreed with the plan to move Baby E to palliative care and that her preference was for him to pass away peacefully, in the care of the grandmother, rather than in hospital and in pain from on-going procedures. She also advised that there would be no issues with the placement arrangement the Department had for the grandmother to look after Baby E.

55 On 19 December 2019, Baby E's placement with the grandmother was approved and she agreed to visit PCH over the next several days for training regarding his care.

56 On 22 December 2019, PCH informed the Department that Baby E was ready for discharge that day. The Department, however, requested that PCH hold the discharge, pending internal approval for palliative care.

57 On 23 December 2019, PCH advised the Department that Baby E's discharge was not conditional upon the Department granting approval for Baby E to receive palliative care. On the same day, the Department approved palliative care.

58 However, on this day, Baby E's mother telephoned the Department and made threats to harm the grandmother and set fire to the grandmother's house if Baby E was discharged into her care. As a result, arrangements were made by the Department for police to issue a police order for 72 hours against Baby E's mother.

59 On 24 December 2019, Baby E was discharged from PCH and placed with the grandmother. The discharge summary from PCH was very detailed. Under the heading "*SPECIAL POINTS OF CONCERN*", it was stated:[18]

> [Baby E] is known to palliative care services at Perth Children's Hospital, however there is no firm sealing of care currently and he should still be assessed if he becomes ill. Discussion between renal team and palliative care

[18] Exhibit 1, Volume 1, Tab 12, Perth Children's Hospital Discharge Summary

> have suggested that intensive care, inotropes, invasive ventilation, central access and cardiopulmonary resuscitation would not be in [Baby E's] best interests however if he comes unwell, has a fever, vomiting or any other concerns he should be assessed and discussed with his treating teams.

60 On 24 December 2019, the grandmother advised the Department she had applied for a Violence Restraining Order (VRO), protecting her from Baby E's mother and a hearing for that application was set for 31 December 2019. An interim VRO was granted on that date and included Baby E and his siblings as protected persons.[19]

61 On 2 January 2020, the Department informed Baby E's mother that it intended to apply for long-term orders regarding her four children.

62 On 21 January 2020, the Department approved funding for the grandmother to attend six sessions with Think Therapy for support and to discuss strategies to manage the four children in her care, and provide a therapeutic environment for her to process the care experiences.

63 On 29 January 2020, Department staff visited Baby E and the grandmother at her home. The grandmother reported that Baby E had grown 1 cm and his weight had increased to 5.7 kg. The Department noted that a Nephrology Registrar at PCH had been impressed with how well Baby E was progressing in the grandmother's care.

64 On 30 January 2020, the Department finalised the Signs of Safety Assessment and Case Planning Form for Baby E and his siblings. It was assessed that the Department would progress applications for Protection Orders (Special Guardianship) for the children, in favour of the grandmother.

Comments on the Department's involvement with Baby E

65 The Department's decision to apply for a provisional protection and care order for Baby E to take effect after his birth was appropriate in all the circumstances. His three siblings were already the subject of provisional protection and care orders and even without Baby E's medical complications, the application would have been appropriate, given the mother's drug dependency.

[19] There was a further condition that Baby E's mother could have contact visits with her children once a week under supervision.

66 I am also satisfied that the Department's decision to place Baby E into the care of the grandmother was correct. I can appreciate why the grandmother was frustrated by the delays in having her assume the care of Baby E. Given his very short life expectancy, I fully understand her desire that he spend as much precious time as possible with his family.

67 Although Mr Geddes conceded in his evidence that the Department could have assessed the grandmother suitability to care for Baby E earlier,[20] I also accept there were explanations for that delay. Those explanations included:

- The initial recommendation from PCH that as Baby E was likely to get infections more easily, a placement with a smaller number of people in the home was preferred.
- The need for the Department to be satisfied that the grandmother would be capable of looking after four children who were all under the age of six, one of whom had complex medical needs.
- The grandmother was overseas from 23 August 2019 to 24 September 2019.
- Although PCH was prepared to discharge Baby E on 22 December 2019, there was a further delay as the Department wanted to obtain internal approval for palliative care.
- After the above approval was made on 23 December 2019, the Department had to ensure adequate safeguards were in place after Baby E's mother had made threats towards the grandmother.

68 On the basis on the evidence contained in the brief and provided by Mr Geddes in his oral evidence at the inquest, I am satisfied the care, supervision and treatment provided by the Department to Baby E was of an acceptable standard.

69 One matter that arose from the oral evidence of Mr Geddes at the inquest was that the Department did not "*have a particular procedure for palliative care"*, although it did "*for end-of-life decision making*".[21] At the end of the inquest, I asked that I be provided with information regarding the Department's policy or procedure regarding end-of-life and palliative care decisions, including the authority for decision-making and what occurs when the parents or primary carer may express an opposing view.[22]

70 By letter dated 20 August 2021 addressed to Counsel Assisting, Ms Rachael Green, the Department's Deputy Director General for Community Services,

[20] ts 20.7.21 (Geddes), p.27
[21] ts 20.7.21 (Geddes), p.29
[22] ts 20.7.21, pp. 47-49

provided a response and attached Chapter 3.2.12 from the Department's Casework Practice Manual. This letter and its attachment became Exhibit 2.

71 Chapter 3.2.12 (the Chapter) is titled "*Termination of life support and palliative care*" and was amended on 16 August 2021 to include guidance on palliative and end-of-life care. I have read the contents of this chapter and am satisfied of the policy and procedures the Department now has in place regarding palliative and end-of-life care for children who are the responsibility of the Department's CEO. Included under the heading "*Overview*" in the Chapter are the following paragraphs:[23]

> The CEO has parental responsibility for a child in their care under a protection order and generally makes decisions about termination of life support and palliative care, in consultation with treating medical practitioners, the child's parents and a child who is Gillick competent. This decision is not delegated to any other Department officer. Where time permits, the child's parents and family **must** be consulted to obtain their views. If there is disagreement between the treating medical practitioners, the child's parents or family, the child, or the CEO regarding termination of life support or palliation, an application is to be made to the Supreme Court (or Family Court of WA where appropriate).
>
> If a child is in provisional protection and care under s.35 or s.37 of the *Children and Community Services Act 2004* (the Act), the CEO does not have the power to make such a decision alone, as the CEO does not have the responsibility for the long-term care, welfare and development of the child (see s.29 of the Act).

CONCLUSION

72 Baby E was born prematurely on 1 July 2019 with an imperforate anus, absent left kidney, dysplastic right kidney, and spinal abnormalities which were attributed to VATER syndrome. He was transferred from KEMH to PCH the day after his birth for urgent bowel and kidney surgery. Baby E required a colostomy bag and had to be fed through a nasogastric tube for the duration of his short life.

[23] Exhibit 2, Chapter 3.2.12 *Termination of life support and palliative care*, p.1

73 Baby E's mother used illicit drugs throughout her pregnancy and, due to concerns for his safety, Baby E was taken into provisional care and protection of the Department's CEO on 8 July 2019.

74 Baby E remained at PCH for over five months and during this time, he developed complications of recurrent aspiration, chronic lung disease, end-stage renal failure and a sacrococcygeal tumour that compressed his spinal cord. His family did not want him to undergo further, painful procedures or kidney replacement therapy due to concerns these would increase his suffering. In December 2019, a decision was made that he be referred for palliative care. Although that was a very compassionate and right decision to make, it still would have been an extremely stressful and difficult one for Baby E's family.

75 Baby E's grandmother was approved as the appropriate carer for him in the community. Baby E was discharged from PCH just in time for his only Christmas. He was able to spend quality time with his siblings and extended family before he died on 1 February 2020.

76 I commend Baby E's grandmother for the love and care she extended to her grandson during his final weeks. It is clear to me that Baby E had a special bond with his grandmother, which was illustrated by the fact that he always followed her with his eyes and would turn his head as he watched her walk around.[24]

77 Having carefully reviewed all the available evidence in this matter, I am satisfied the standard of care, supervision and treatment of Baby E received from the Department was appropriate. The care and treatment Baby E received from the medical staff at PCH was of a very high order and it is a tragic regret that the prospect of Baby E's long-term survival was always going to be extremely low, notwithstanding that level of care.

PJ Urquhart
Coroner
26 August 2021

[24] Exhibit 1, Volume 1, Tab 10, Statement – Baby E's grandmother dated 27 April 2020, p.6

I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.

CORONER P Urquhart

26 AUGUST 2021