JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART
HEARD	**:**	26 - 27 NOVEMBER 2020
DELIVERED	**:**	22 JUNE 2021
FILE NO/S	**:**	CORC 1106 of 2015
DECEASED	**:**	Child AM

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W Stops assisted the Coroner
Ms H Levy (Kimberley Community Legal Services) appeared on behalf of the family
Mr E Cade (State Solicitor's Office) appeared on behalf of the Department of Communities and the Child and Adolescent Health Service
Ms K Lendich instructed by Jehan-Philippe Wood (Clyde & Co) appeared on behalf of Life Without Barriers

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

Nil

Coroners Act 1996
(Section 26(1))

AMENDED RECORD OF INVESTIGATION INTO DEATH

*I, Philip John Urquhart, Coroner, having investigated the death of a female child referred to as **Child AM** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 26 - 27 November 2020, find that the death of **Child AM** occurred on 4 September 2015 at Joondalup Health Campus, from bronchopneumonia in an infant with obstructive sleep apnoea in the following circumstances:*

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SUPPRESSION ORDER

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

The deceased is to be referred to as Child AM.

INTRODUCTION

1. The deceased (Child AM) died on 4 September 2015 from bronchopneumonia. She was 3 years and 11 months old. At the time of her death, Child AM was in the care of the Chief Executive Officer (CEO) of the Department of Child Protection and Family Support (the Department).[1]

2. Accordingly, immediately before her death, Child AM was a "*person held in care*" within the meaning of the *Coroner's Act 1996* (WA) and her death was therefore a "*reportable death*".[2]

3. In such circumstances, a coronial inquest is mandatory.[3] Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received from the Department while in that care.[4]

4. I held an inquest into Child AM's death at Perth on 26-27 November 2020. The following witnesses gave oral evidence:

i. Dr Helen Wright (general paediatrician at Perth Children's Hospital);
ii. Mr Roderick Best (special counsel at Life Without Barriers);
iii. Dr Lana Bell (general paediatrician at Joondalup Health Campus and Perth Children's Hospital);

[1] Now the Department of Communities
[2] Section 3, *Coroners Act 1996* (WA)
[3] Section 22(1)(a), *Coroners Act 1996* (WA)
[4] Section 25(3), *Coroners Act 1996* (WA)

iv. Mr Andrew Geddes (regional director of the Department's South Metropolitan Region);
v. Ms Ashley Daily (case worker at Life Without Barriers).

5. The documentary evidence at the inquest comprised of four volumes which were tendered as Exhibit 1. An additional exhibit was tendered during the course of the inquest and it became Exhibit 2.

6. My primary function has been to investigate Child AM's death. It is a fact-finding function. I must find, if possible, how Child AM's death occurred and the cause of her death.[5]

7. I may also comment on any matters connected with Child AM's death, including public health or safety or the administration of justice.[6] This is an ancillary function of a coroner.

8. The inquest focused on the involvement of the Department in Child AM's life and the treatment of Child AM by medical staff at the hospitals where she was a patient, most notably Princess Margaret Hospital (PMH).

9. On the basis that it will be contrary to the public interest, the State Coroner made a suppression order with respect to Child AM's name on 19 August 2019, pursuant to Section 49 (1) of the *Coroners Act 1996* (WA). The terms of that order are set out on page 3.

10. At the end of the inquest, Ms Lendich SC, counsel for Life Without Barriers (LWB), and Mr Cade, counsel for the Child and Adolescent Health Service (CAHS) and the Department, made oral submissions. Mr Cade supplemented his submissions with a seven page written schedule. Ms Levy, counsel for the Family, requested that she provide a written submission to enable her to take instructions. That request was granted and Ms Levy agreed to file those submissions by 4 December 2020. By letter dated 9 December 2020 to Counsel Assisting, Ms Levy sought an extension of time to provide written submissions "*by no later than close of business 21 December 2020*". I

[5] Section 25(1)(b) and (c), *Coroners Act 1996* (WA)
[6] Section 25(2), *Coroners Act 1996* (WA)

granted that extension. No submissions were received by that date. By email dated 7 January 2021 to Counsel Assisting, Ms Levy outlined her difficulties in obtaining instructions and sought a further extension to provide written submissions by 18 January 2021. I granted a further extension to that date. By letter dated 19 January 2021 to the court, Ms Levy advised that with respect to the two issues addressed by the other counsel in their oral submissions "*the family supports the submissions of the State Solicitor's Office and does not wish to make further submissions on those matters*".

11. In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361-362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

12. A list of abbreviations, which I hope will assist the reader, is included as Annex A at the end of this finding.

CHILD AM'S MEDICAL ISSUES

13. Child AM was born in a remote community in the East Kimberley on 15 September 2011. She was the first child to her parents.[7] Her birth weight was regarded as low at 2.82 kg.[8] Child AM participated in a traditional Aboriginal ceremony in the early days of her life to help her gain weight. It appears that she soon developed a voracious appetite. Her family are of the view that the Aboriginal ceremony was the cause of Child AM's on-going weight issues.

14. On the other hand, Dr Bell was of the view that Child AM's progression to childhood obesity was due to eight factors which she listed (in no particular order) as:[9]

i. Increased calorie intake;

[7] Exhibit 1, Vol 1, Tab 8A, Report – Jackie Tang dated 18 December 2018, p.1
[8] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.2
[9] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.1

ii. Hyperphagia (excessive food demand caused by an insatiable appetite);
iii. Decreased physical activity;
iv. Cultural norms;
v. Behavioural difficulties and carer response;
vi. Biological factors prior to birth;
vii. Homozygosity of the genome (a past shared ancestry between her parents which may have been a genetic contributor to her hyperphagia and global developmental delay),[10] developmental delay; and
viii. Rural/remote location and Indigenous heritage.

15. It is evident that Child AM experienced rapid and excessive weight gain from a very early age. At the time of her death, she weighed 36 kg.[11] At one stage she was as heavy as 41.2 kg.[12] The usual weight for a child of AM's age when she died is around 14-16 kg.[13]

16. The health consequences of Child AM's significant obesity were substantial. They included:[14]

i. Obstructive sleep apnoea (complete or partial obstruction of the upper airway during sleep);
ii. Obesity-hypoventilation syndrome requiring supportive ventilation;
iii. Right heart ventricular hypertrophy (enlarged chambers pumping blood through the heart);
iv. Severe pulmonary hypertension (raised blood pressure in the lung circulation);
v. Hyperinsulinemia (raised insulin levels) with insulin resistance; and
vi. Hypercholesterolemia (elevated amounts of cholesterol in the blood).

[10] Dr Bell stated that this cause was unclear without an opinion from a geneticist: Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.5
[11] Exhibit 1, Vol 1, Tab 4, Post-Mortem Report of Dr Judith McCreath dated 7 September 2015, p.2
[12] Exhibit 1, Vol 1, Tab 10A, PMH Inpatient Discharge Letter dated 29 June 2015, p.1
[13] ts 26.11.20 (Dr Wright), p.28
[14] Exhibit 1, Vol 1, Tab 10A, Report – Dr Helen Wright dated 23 December 2015, p.1

17. Child AM also experienced unexplained episodes of transient loss of consciousness and global developmental delay.[15] The latter condition meant that Child AM had significant delays across all her cognitive and physical developmental milestones. When aged 3 years, 8 months she underwent a standardised series of tests that looked at all aspects of her development. That assessment found that she had the equivalent age of a child who was 2 years, 3 months old.[16] Child AM also had constipation, vitamin D and iron deficiencies, right middle lobe consolidation (fluid in the airspaces of the lung) and asthma.[17]

18. Even at the young age of 2 years, 3 months, Child AM's obesity was considered a threat to her life based on the complications of severe asthma and her obstructive sleep apnoea.[18]

CHILD AM'S MEDICAL TREATMENT [19]

19. From 17 November 2011 to 22 March 2014 Child AM was evacuated from the community in the East Kimberley where she lived on 12 occasions with obesity related health issues. She was mainly admitted to Brome Hospital (BH) but also spent time in Royal Darwin Hospital (RDH) and Halls Creek Hospital.

20. Child AM was referred by a paediatric registrar from the Kimberley Health Region (KHR) paediatric team to a Paediatric Respiratory Consultant for a respiratory assessment. This consultant saw Child AM at the Respiratory Outreach Clinic in Broome on 1 November 2013. Following that assessment it was recommended that Child AM be admitted to PMH for a multidisciplinary assessment. Her case was presented by the KHR paediatric team to the PMH Green medical team via video conference on 2 December 2013 to plan the admission.

[15] Exhibit 1, Vol 1, Tab 10A, Report – Dr Helen Wright dated 23 December 2015, p.1
[16] ts 26.11.20 (Dr Wright), pp.20-21
[17] Exhibit 1, Vol 1, Tab 10A, Report – Dr Helen Wright dated 23 December 2015, p.2
[18] Exhibit 1, Vol 1, Tab 10A, Report – Dr Helen Wright dated 23 December 2015, p.2
[19] Exhibit 1, Vol 1, Tab 10A, Report – Dr Helen Wright dated 23 December 2015; Exhibit 1, Vol 2, Princess Margaret Medical File; (this includes medical records from RDH); Exhibit 1, Vol 3, Tabs 1 and 2, Child and Adolescent Mental Health Service Acute Services File and Joondalup Health Campus Medical File; Exhibit 1, Vol 1, Tab 14, St John Ambulance, Patient Care Record

21. Child AM was admitted to PMH on 5 December 2013 where she remained until her discharge on 24 December 2013. During this admission she was assessed by multiple health professionals from general paediatrics, genetics, endocrinology, respiratory medicine, dietetics and physiotherapy. Her admission weight was recorded as 27.9 kg. An underlying diagnosis for Child AM's obesity and hyperphagia could not be found despite multiple investigations which included a magnetic resonance imagery (MRI) scan of her brain.

22. During this hospital admission safety concerns were raised as Child AM's family continued to feed her fast food, cakes and soft drinks when visiting.

23. Discharge planning was extensive and it was eventually determined that Child AM would be transferred back to BH. Her weight on the day before her discharge from PMH was 27.2 kg.

24. Child AM remained in BH for another two months before she was discharged on 25 February 2014. She was readmitted to BH in March, April and May of 2014.

25. On 29 May 2014 Child AM was referred to Aboriginal Ambulatory Care Coordination (AACC) which discussed her case and made a plan for her care. This included a referral to the Aboriginal Health Team (AHT) and to a general practitioner who was present when the plan was made.

26. Child AM was also reviewed by her paediatric team at PMH on 29 May 2014. Her care plan concentrated on activity and meal plans. She was also referred to the Changes in Lifestyle are Successful in Partnership (CLASP) program. This program was an outpatient, family-based, lifestyle and educational weight management program at PMH. On 4 June 2014 CLASP accepted the referral and offered an assessment for Child AM that was subject to seeing if the current change of environment (Child AM was then in foster care) would result in an improvement in her weight.

27. On 26 June 2014 Child AM was referred to the Child Development Service for occupation therapy and physiotherapy. The CLASP referral was placed on hold. Less than two months later Child AM was placed in the care of her maternal grandparents. As the grandparents lived in Broome, the CLASP referral could not be actioned.

28. A planned sleep study for Child AM was undertaken on 3 July 2014 at PMH. The results of that sleep study were alarming. As reported by Dr Andrew Wilson, a Paediatric Respiratory Consultant:

> Abbreviated but very abnormal study. Evidence of obstruction with frequent obstructive events. Baseline oxygen desaturation during sleep, with elevation in TcCO2 to the low 60's (confirmed with end-tidal CO2). Pattern suggests severe obstructive hyperventilation/evolving obesity-hypoventilation syndrome.

29. These results led to Child AM being admitted to PMH on the same day. She remained there until 31 July 2014.

30. On 5 July 2014 Child AM was fitted with a bubble continuous positive airway pressure (CPAP) machine due to her obstructive sleep apnoea.[20]

31. During this hospital stay Child AM had a chest computerised tomography (CT) scan which showed atelectasis (partial collapse) of the middle lobe and upper left lobes of her lungs.

32. On 14 July 2014 Child AM underwent an adenotonsillectomy (removal of the adenoids and tonsils) in an effort to improve her sleep apnoea.

33. On 31 July 2014 Child AM was discharged from PMH into the care of her foster carer. Three days before this discharge her weight was recorded as 25.7 kg.

34. On 16 September 2014 Child AM was seen at the Broome Respiratory Outreach Clinic. It was noted that Child AM required at least four

[20] A CPAP machine treats sleep apnoea by delivering a stream of oxygenated air into the wearer's airways through a mask and a tube. This is to overcome a collapse of the upper airway during sleep. A bubble CPAP is specifically designed for newborns and infant.

hours every night on the CPAP machine. It was emphasised that the use of the CPAP machine had to be very strict in routine.

35. A further outpatient sleep study was undertaken at PMH on 30 September 2014. On this occasion the paediatric consultant noted that there was "*fairly good control*" of Child AM's obstructive sleep apnoea and there was a *"great improvement"* in the baseline oxygen saturations and TcCO2 compared to the previous study. However it was noted Child AM displayed poor tolerance of the machine.

36. On 4 November 2014 AACC conducted a multidisciplinary team meeting with paediatric staff based in Broome and PMH. A plan was made for Child AM's care in Broome.

37. On 25 November 2014 Child AM was not taken to her appointment at the Respiratory Outreach Clinic in Broome.

38. On 3 January 2015 Child AM was admitted to RDH with bilateral mycoplasma pneumonia and respiratory failure that required intubation and admission into RDH's Intensive Care Unit. An echocardiogram (ECG) showed severe pulmonary hypertension. Child AM remained in a RDH until 21 January 2015.

39. Following her discharge Child AM was referred to the CLASP program again. She was also referred to the Child Development Service for occupation therapy and physiotherapy. This service was operated by CAHS.

40. On the 27 February 2015 Child AM was admitted to BH with asthma. She was discharged on 3 March 2015.

41. On 14 March 2015 Child AM was reviewed by a doctor at BH's Paediatric Cardiology Clinic (PCC). After conferring with other health professionals responsible for treating Child AM, it was recommended that a plan be put in place for another admission to PMH. That admission was scheduled for 6 April 2015.

42. On that date during the flight from Broome to Perth, Child AM became unresponsive with urinary and faecal incontinence and pin-

point pupils. She was subsequently admitted to PMH through the emergency department.

43. Child AM remained at PMH until 29 June 2015. During the first month of this hospitalisation she continued to have episodes of unconsciousness for up to 20 minutes at time. No clear cause for these episodes was found and they eventually resolved during her hospital stay.

44. An ECG on 9 April 2015 detected a mild pulmonary arterial hypertension which was found to have improved following another ECG on 26 June 2015.

45. During this hospital admission Child AM was also reviewed by a consultant paediatric neurologist who reviewed Child AM on 8 and 10 May 2015. An electroencephalogram (EEG), a medical test used to measure the electrical activity of the brain, was normal and a genetic test for narcolepsy (a chronic sleep disorder that causes extreme daytime drowsiness) was negative.

46. A review by an endocrinologist found that Child AM's hyperinsulinemia had seemed to resolve, with testing showing a normal insulin level on 9 April 2015. It was also noted that Child AM had lost weight, was less short of breath and her mobility had improved.

47. A multidisciplinary team meeting was held on 22 May 2015. It was noted that Child AM's weight had reduced since admission and as her episodes of loss of consciousness had reduced in frequency, a discharge was arranged. That discharge eventually took place on 29 June 2015 into the care of a new foster carer. Child AM's weight was recorded as 34 kg on discharge which was a significant weight loss since her admission. By this stage Child AM had switched from a CPAP machine to a BiPAP (bi-level positive airway pressure) machine.[21]

[21] This machine is similar to a CPAP machine as it works by sending air through a tube into a mask that fits over the nose. The difference is while a CPAP machine generally delivers a single pressure, a BiPAP machine delivers two: an inhale pressure and an exhale pressure.

48. On 28 July 2015 a CLASP review was conducted. It was noted that Child AM's dietary instructions were not being followed when she attended respite care and that she was only using the BiPAP machine intermittently. She also encountered difficulties staying awake during the day. It was determined to revert back to a CPAP machine and melatonin was prescribed to improve Child AM's night-time sleep quality.

49. Another outpatient sleep study involving Child AM took place at PMH on 3 and 4 August 2015. The paediatric consultant reported that Child AM's obstructive behaviour to the use of the CPAP machine had continued and that it was only being used on average for 1.8 hours every night. It was suggested that the BiPAP machine be reintroduced, with another sleep study taking place once it had been in use at home.

50. On 1 September 2015 Child AM had a respiratory clinic appointment which a staff member from AACC also attended. Child AM was examined by a doctor specialising in endocrinology. It was noted that her weight was stable at 36 kg, that she was more active, had improved sleep and could be distracted from food-seeking behaviours. Child AM had a current chest infection that was being treated with antibiotics prescribed by a general practitioner. The plan was to continue on the BiPAP machine and the melatonin to assist with sleep.

51. On 3 September 2015 Child AM woke up with diarrhoea although she otherwise appeared normal. She had follow-up appointments with the occupational therapist and physiotherapist and did not appear unwell. Between 6.30 pm and 7.00 pm she had dinner and then laid down on the floor to watch television as she did every night. She then fell asleep. Her female carer was unable to lift her as she was too heavy and so she waited for her partner to return home at about 11.00 pm. However, when attempting to move Child AM, the partner found her to be unresponsive. Child AM's female carer then began CPR (cardiopulmonary resuscitation), however Child AM's jaw was locked. The carer then contacted her mother who was a nurse and lived close by. The carer's mother arrived and took over resuscitation attempts until paramedics attended.

52. The triple zero call was made at 11.06 pm and an ambulance arrived at 11.16 pm. By then Child AM had no output, no respiratory effort and was cold to the touch. CPR was continued and the initial heart rhythm was asystole (cardiac arrest in which the heart stops beating). The paramedics were unable to intubate due to the spasm of the jaw. Instead an oropharyngeal (a medical device used to open a patient's airway) was inserted with some difficulty. Child AM was then conveyed by ambulance to Joondalup Health Campus (JHC), arriving at 11.52 pm.

53. Upon admission to JHC further resuscitation efforts continued; including CPR, the administering of dextrose, adrenaline and atropine. Despite those concerted efforts by hospital staff, Child AM remained asystole. CPR was ceased at 12.17 am on 4 September 2015 and Child AM was certified as having died.

THE DEPARTMENT'S INVOLVEMENT IN CHILD AM [22]

Contact with the Department by Child AM's family before her birth

54. Child AM was the first child of her parents. The first reported contact with the Department by the family was in 2007 for financial assistance.

First provisional protection and care of Child AM by the Department

55. In June 2013 a referral was received by the Department's East Kimberley District Office from a doctor at the community health clinic that Child AM was attending. The doctor expressed concern for her health due to her obesity and developmental delay.

56. On 3 July 2013, the Department commenced a Safety and Wellbeing Assessment (SWA) regarding Child AM who was then 22 months old. The Department assisted Child AM's family to travel so that Child AM could undergo a series of medical examinations.

[22] Exhibit 1, Vol 1, Tab 8 A-C, Report – Jackie Tang dated 18 December 2018; Statement – Fiona Fischer dated 4 March 2020 with six attachments; Supplementary Report – Lindsay Hale dated 15 April 2020

57. The Department's investigations concluded that no harm was caused to Child AM and there was no deliberate act by her family to neglect her needs. However, the SWA highlighted the difficulties with providing medical services to children living in remote areas and noted the lack of adequate communication with her family.

58. The SWA concluded that medical neglect was unsubstantiated as:

> The outcome of the tests and assessment did not show any child protection issues, the family have returned to their home in [the East Kimberley] community. This community has limited services however it does have a community health clinic and the family are engaged with this service and are fully compliant with all the requests from health, at this time.

59. Nevertheless, the Department initiated a period of Child Centred Family Support to assist Child AM's family and she was referred to the Kids at Risk meetings so she could be monitored.

60. On 2 October 2013 the Department received further concerns for Child AM's health; this time by a paediatrician at BH. Child AM had been admitted the previous day with asthma related problems. Medical staff at BH found that despite her mother being provided a feeding plan, Child AM had gained about one kg since her discharge from BH in July 2013. The Department was also advised Child AM should be losing about one kg every 10 days and that she currently weighed 25.2 kg. The average weight of a child of her age and height was 13-15 kg. The Department was also advised that Child AM was suffering from obstructive sleep apnoea and there was a risk her windpipe could become obstructed during sleep with the potential to cause her death. Child AM was also unable to stand or walk due to her excessive weight and there was a concern there were insufficient services in the community where Child AM resided to assist with monitoring and supporting efforts to reduce her weight.

61. In response to this doctor's concerns, the Department made arrangements for a remote Senior Community Child Protection Worker to liaise directly with Child AM's family and other

community-based services to encourage and support her family to follow the health care plans.

62. Unfortunately, despite these measures, Child AM's health did not improve. She had to be medically evacuated five times from her community due to breathing difficulties. On these occasions she was either admitted to the Halls Creek Hospital or BH.

63. In May 2014 the Department's East Kimberley Office investigated allegations of medical neglect as Child AM's parents had not been compliant with medical advice. This meant that for the past six months she had not been able to reside out of hospital for longer than a week.

64. At a multiagency case conference held on 5 May 2014, a health staff member advised that Child AM's medical condition had deteriorated to such an extent that her return to her community would become a major threat to her life due to her ongoing obesity.

65. On this occasion medical neglect was substantiated and on 8 May 2014 Child AM entered into the provisional protection and care of the Department's CEO under Section 37 of the *Children and Community Services Act 2004* WA (the Act). An application was then filed by the Department in Perth Children's Court for a time-limited Protection Order under Section 51 (1) of the Act for Child AM.

66. Child AM remained a patient at BH until 22 May 2014 when she was discharged into the care of the Department's CEO. The following day she was flown to Perth and from 23 May 2014 until 17 August 2014 she was in a foster care arrangement organised by Life Without Barriers (LWB). LWB is an organisation that provides services to children and young people including those with complex medical needs. Pursuant to Section 79 (2)(a) of the Act, LWB had a Service Agreement with the Department to provide day-to-day care for children in the care of the Department's CEO.

67. During AM's placement with LWB foster carers, an application was filed by Child AM's maternal grandmother to have Child AM placed in her care. On 27 June 2014, an interim order pursuant to Section 133

(2)(c) of the Act was granted by the Perth Children's Court which placed Child AM with her grandmother, subject to certain conditions.[23] Those conditions had been met by 17 August 2014 and on that date Child AM returned to Broome from Perth to live with her maternal grandparents. In accordance with Section 29 (3)(c) of the Act, the provisional protection and care status of the Department's CEO ceased.

Second provisional protection and care of Child AM by the Department

68. From 17 August 2014, the Department continued to liaise with Child AM's grandmother and a worker from the Department's Broome office was allocated to provide local support. A referral was also made to the Strong Families Program and an initial meeting was held on 26 September 2014 aimed at coordinating multiple services to assist Child AM's family. Those attending this meeting included Child AM's grandparents, medical staff from BH and the Department. A planned meeting four weeks later was cancelled as Child AM's family were in the East Kimberley community and it was rescheduled for 31 October 2014. However that meeting did not take place, nor any others.

69. Although the Department was not responsible for no future meetings taking place, it was most unfortunate this occurred. This program was established to achieve a planning and coordination process for families who are receiving services from a number of agencies and who would benefit from a more formal coordination process that would assist in better achieving the desired outcomes for the family.[24] Such a process was custom built for a family such as Child AM's.

70. In early October 2014 Child AM's family made plans to travel to a remote Kimberley location for the funeral of a relative. Understandably, the Department held concerns about the implementation of the agreed health management plan for Child AM

[23] Those conditions were that: (1) the grandmother was to live in a property in Broome that had been leased for at least six months and she was to live in that property with no one else other than her husband and daughter; (2) the grandmother was to comply with a health management plan negotiated between herself, the Department and medical staff at BH and (3) placement of Child AM into the grandmother's care was not to take effect until conditions (1) and (2) had been satisfied.

[24] www.mycommunitydirectory.com.au/WesternAustralia/Perth/Child_Services/Child_and_Parent_Information_Counselling

when she was away from Broome. As she was not in the protection and care of the Department's CEO, there was no input from the Department in relation to this trip. There were concerns regarding an adequate power supply for the operation of Child AM's CPAP machine. The Department became aware Child AM had been away from Broome for at least one week and when she was weighed after her return on 14 October 2014, her weight had increased to 27.5 kg. This was an increase of 2.59 kg since she had returned to her grandparent's care less than two months earlier.

71. There were further developments that raised some apprehension for Child AM's wellbeing. The dietician in Broome working with the family raised concerns that Child AM's grandmother was not coping with the care of Child AM. On 27 October 2014, the grandparents asked the dietician when they could return Child AM to her biological mother as they were not coping with the demands of looking after her.

72. On 29 October 2014 the worker allocated from the Department's Broome office to provide support for Child AM's grandparents completed a home visit. The grandmother described that living in Broome was *"too hard"* and referred to financial difficulties. She also expressed a desire to return to the community in the East Kimberley.

73. On 10 December 2014 the Department contacted the community health clinic that had previously treated Child AM. It was confirmed that Child AM had been living in the East Kimberley community for approximately three weeks. This would appear to be in contravention of the interim order made by the Perth Children's Court on 27 June 2014.

74. On 15 December 2014 Child AM was seen by a Department worker in the East Kimberley community. She now weighed 33 kg and her chest had a *"rattle"*. Child AM had put on 8 kg in just four months.

75. On 30 December 2014 a senior paediatrician at BH confirmed that Child AM's family had had a discussion with medical staff at PMH, Broome and the clinic nurse at the East Kimberley community. On that occasion it was agreed Child AM could return to the community

for a two week trial period to see if it would be feasible for her to move back longer term in the future. It would seem that the health providers involved in those discussions were unaware of the interim order imposed in June 2014.

76. The Senior Regional Paediatrician for the Kimberley wrote the following in an email to the Department on 31 December 2014:

> [Child AM] has been medically stable for some time now, and has not required admission to hospital for a number of months. The information I have been provided by the clinic staff at [the community in the East Kimberley] does not indicate that she has become medically unstable. On this basis I feel it is entirely appropriate for her to be transported to Halls Creek in a private vehicle without a medical escort, and then to Broome on a bus [for her medical treatment].

77. Although this email was written in the context of an alternative means of transport other than flying to Broome if Child AM required medical treatment, it does not appear to place sufficient attention to Child AM's rapidly increasing weight, which would increase the health risks of her obstructive sleep apnoea. That increase in her health risks came to fruition three days later when Child AM was evacuated by the Royal Flying Doctor Service (RFDS) and taken to RDH due to an acute deterioration of her respiratory functioning. At the time of her admission into RDH (where she remained for 18 days), Child AM weighed 36 kg. This was an increase of 3 kg in less than three weeks.

78. On 6 January 2015, the Department conducted a second SWA and found that Child AM had been medically neglected.

79. On 21 January 2015, the Department filed an application for an interim order under Section 37 of the Act, requesting that the previous interim order be revoked and that Child AM be placed into the provisional protection and care of the Department's CEO. This application was granted on 30 January 2015, however Child AM began living with her maternal grandparents who were now residing in Broome.

80. During this time Child AM had regular medical oversight and review through the Broome Regional Aboriginal Medical Service, BH and PMH. She was also reviewed under the Interagency Kids At Risk meetings. However her weight continued to rise and on 12 March 2015 she was 39.4 kg.

81. On 6 April 2015 Child AM was admitted to PMH where she remained for nearly three months. This admission was a part of a planned medical intervention to monitor her respiratory conditions and introduce a controlled weight loss program.

82. Given the progress Child AM had made while at PMH, including weight loss, the Department made the decision to find an alternative placement for Child AM.

83. On 20 May 2015, the Department sent a Request for Quote to 12 Community Sector Organisations under the Specialised Fostering Program. Quotes were received from LWB and another organisation. The LWB quote and its recommended carers were accepted by the Department due to the carers being located closer to PMH, LWB having cared for Child AM the previous year and the female carer being a stay at home carer. On 29 June 2015 Child AM was discharged from PMH to these carers.[25]

84. Child AM remained in that care until her death on 4 September 2015.

CAUSE AND MANNER OF DEATH

Cause of death [26] [27] [28]

85. Dr Judith McCreath, a forensic pathologist, conduct a post mortem examination on Child AM on 7 September 2015.

86. That examination noted that Child AM weighed 36 kg and was 1.13m in height. Dr McCreath observed no evidence of any injuries. There

[25] These were not the carers who had looked after Child AM in 2014 as they did not have the capacity to care for her in 2015 due to other foster care commitments: ts 26.11.20 (Daily), p.98
[26] Exhibit 1, Vol 1, Tab 4, Post-Mortem Report and Supplementary Report – Dr Judith McCreath
[27] Exhibit 1, Vol 1, Tab 5, Neuropathology Report – Dr Viki Fabian dated 29 September 2015
[28] Exhibit 1, Vol 1, Tab 6, Toxicology Report dated 14 January 2016

was evidence of medical intervention consistent with attempts to resuscitate Child AM. Dr McCreath ordered that further investigation should be performed; including a toxicological analysis, a microbiological examination of the lungs, bowel and spleen, neurology examination of the bowels, spleen, liver and heart and a neuropathology examination of the brain.

87. Following the completion of those examinations, Dr McCreath reported the following:

> Microscopic examination of tissue showed pneumonia in the lungs. Neuropathological examination of the brain macroscopically showed no significant abnormalities. Microbiological cultured, blood and splenic and lung tissues grew methicillin resistant Staphylococcus aureus. Cultures of lung tissue also grew Haemophilus influenza … Virology examination of large bowel, small bowel and lung showed the presence of Enterovirus/Rhinovirus RNA … Toxicological analysis of blood was negative for alcohol and common drugs.

88. After reviewing the results of the above examinations, Dr McCreath expressed the opinion that the cause of Child AM's death was "*bronchopneumonia in an infant with obstructive sleep apnoea*".

89. I accept and adopt the conclusion of the cause of death as expressed by Dr McCreath. I find that the cause of Child AM's death was bronchopneumonia in an infant with obstructive sleep apnoea.

Manner of death

90. I find that Child AM had a large range of medical complications that began shortly after she was born. Many of those complications arose from her obesity, most notably her obstructive sleep apnoea. In combination, those medical conditions meant Child AM's life was always at risk. As stated by Dr Bell:[29]

> [A]lthough there has been much focus on the last few months of the child's life, this was a child that was at significant risk for many years, you could argue before even the child was born. And that, in some ways – it almost –

[29] ts 26.11.20 (Dr Bell), p.69

> almost any changes that we could make, in retrospect, would – might have altered the timing, but I do not believe they would have altered the outcome.

91. Accordingly, I find that Child AM's death occurred by way of natural causes.

MATTERS RAISED IN COUNSELS' CLOSING SUBMISSIONS

92. At the conclusion of the oral evidence at the inquest, I invited counsel to address two matters in their closing submissions.

93. The first matter concerned a sentence that appeared in the Department's Placement Referral for Child AM dated 1 May 2015. Under the heading "*Reason for Referral and Current Case Arrangement*" the final sentence read, "*the level of care required in regards to* [Child AM's] *medical needs is not high – the need for firm and consistent boundaries around food will be the biggest challenge*."[30]

94. The second matter was whether Child AM's last foster carers were adequately prepared for and properly advised of Child AM's needs; particularly her medical needs which included the adequacy of the training received by the female carer at PMH for the BiPAP machine before Child AM's discharge.

The sentence in the Placement Referral

95. When taken to the sentence referred to above, Mr Geddes in his evidence at the inquest stated, "*I am not sure, with hindsight, that's the right choice of words to use…*"[31] That concession was properly made by Mr Geddes and I find that this sentence inaccurately described the level of care required in regard to Child AM's medical needs. Those medical needs were clearly significant. To cite one example: the need for the BiPAP machine to be affixed to Child AM's

[30] Exhibit 1, Vol 4, Tab 1.10, Placement Referral dated 1 May 2015
[31] ts 26.11.20 (Geddes), p.91. In answer to a question after he gave that evidence, Mr Geddes agreed that the medical needs of Child AM being stated as "*not high*" was "*a wrong description*".

head for at least four hours every night during her sleep was always going to be a major challenge.

96. However, that sentence must not be read in isolation. The question that arises was whether LWB was misled to any significant degree by that sentence or whether, in the context of all the information LWB had at the time, the inaccurate description was not a significant error.

97. In her closing submissions, Ms Lendich, counsel for LWB, did not invite me to make a finding that LWB had in fact been misled by the Department in relation to the medical needs to Child AM.[32] However, Ms Lendich submitted that LWB's concern was that the sentence contained an assessment of a level of care required for Child AM at a time when the Department had far more information than LWB.[33]

98. I accept Ms Lendich's distinction between "*care needs and medical needs*" in that Child AM's medical needs were to be met by her treating doctors and the care needs were to be met by her foster carers.[34] I also accept that Child AM had "*both high medical needs and high care needs*".[35]

99. I agree with Ms Lendich's concession that LWB had not been misled by the contents of this sentence. However, Ms Lendich contended that the Department did not provide sufficient information to LWB regarding the high level of care that Child AM was going to require.

100. I am not prepared to accept that the Department's instructions to LWB as to the care required for Child AM were so deficient as to warrant criticism. In making that conclusion I take into account all the information that LWB had regarding Child AM. Of significance is the fact that LWB had prior experience with providing a foster care arrangement for Child AM in 2014, albeit with different carers. That arrangement was from 23 May 2014 to 13 August 2014.[36] On that occasion Child AM had exhibited similar needs and behaviours. At a LWB "Out of Home Care" panel meeting on 6 June 2014, Child AM

[32] ts 27.11.20 (Closing Submissions by Ms Lendich), p.126.
[33] ts 27.11.20 (Closing Submissions by Ms Lendich), p.127
[34] ts 27.11.20 (Closing Submissions by Ms Lendich), p.127
[35] ts 27.11.20 (Closing Submissions by Ms Lendich), p.127
[36] Exhibit 1, Vol 4, Tab 2, Statement – Ashley Daily dated 20 November 2020, p.2

was noted with risk categories of *"high clinic"* and *"high medical"*. It also highlighted a number of behavioural issues that would require a high degree of monitoring by Child AM's carers.[37]

101. I also note that the LWB manager for the first foster care placement in 2014 also oversaw the second foster care placement in 2015 until the end of July.[38]

Level of preparation provided to Child AM's last foster carers

102. Mr Cade, counsel for the CAHS and the Department, contended that Child AM's last foster carers were adequately prepared for and advised of her needs, including her medical needs. On the other hand, Ms Lendich submitted that the foster carers were not. She further submitted that was not the fault of LWB as it had not been properly advised of the needs for Child AM by the Department.

103. The statements of the two foster carers who cared for Child AM from 29 June 2015 to 4 September 2015 detail the significant difficulties they faced looking after Child AM.[39] These carers had been fostering children through LWB for over two years and were regular respite carers for three young boys.[40] When they put in an application to care for Child AM they had been told some details about her including her age, that she was overweight and that she required a healthy lifestyle.[41]

104. The female carer first met Child AM at PMH on 22 June 2015. It was on that occasion she says she was informed for the first time that Child AM had further medical problems including global developmental delay, obstructive sleep apnoea and that she was known to have periods of loss of consciousness. She was also informed it was hard to wake Child AM from sleep or when she was in those states of unconsciousness. She was also told that Child AM had asthma, although that had not formally been diagnosed due to her

[37] Exhibit 1, Vol 4, Tab 2.7, LWB Out of Home Care panel meeting dated 6 June 2014
[38] ts 22.11.20 (Daily), p.106
[39] Exhibit 1, Vol 1, Tab 11,. Statement – Female carer dated 4 September 2015; Exhibit 1, Vol 1, Tab 13, Statement – Male Carer dated 5 September 2015
[40] Exhibit 1, Vol 1, Tab 12, Statement – Female carer dated 4 September 2015, [4]-[5]
[41] Exhibit 1, Vol 1, Tab 12, Statement – Female carer dated 4 September 2015, [13]

age.[42] The female carer spent a week visiting and bonding with Child AM, which included a night spent learning how to use Child AM's BiPAP machine. This training took place on the night of 25 and 26 June 2015.

105. Entries in PMH's In Patient Progress Notes make it clear that this training was not a pleasant experience for the female carer. The nursing entry for the 26 June 2015 relevantly read: [43]

> Foster Mo [Mother] in attendance. On BiPAP with setting 14/9 while asleep… Woke multiple times overnight. Settled back to sleep… Foster MO [Mother] tearful +++. Spoke with FMO [Foster Mother], she disclosed she was not aware of all behaviour or care issues and felt exhausted and overwhelmed. Was also unaware until yesterday that she was required to stay overnight… FMO [Foster Mother] unable to sleep and advised to go home and get some sleep tonight and revisit the situation tomorrow.

106. A later entry from the Child Protection Unit [CPU] on 26 June 2015 read:[44]

> Meeting with foster carer + Life Without Barriers staff. Discussed concerns re: o/n [overnight]. Foster mo [mother] was feeling overwhelmed by number of PMH staff meeting w [with] her and felt overloaded by info. FMO [foster mother] very keen to care for [Child AM] and feeling very positive today.

107. A further entry by a social worker and a worker from AACC dated 26 June 2015 at 2.20 pm included the following entry:[45]

> Discussed last night's experience [female carer] was overwhelmed but still keen to care for [Child AM] as per plan.

108. These final two entries are consistent with the female carer's statement in which she said: "*I was committed to caring for* [Child AM] *even though it was difficult due to her medical issues.*"[46]

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[42] Exhibit 1, Vol 1, Tab 12, Statement – Female carer dated 4 September 2015, [21]-[22]
[43] Exhibit 2, In Patient Progress Notes for Child AM from PMH
[44] Exhibit 2, In Patient Progress Notes for Child AM from PMH
[45] Exhibit 2, In Patient Progress Notes for Child AM from PMH

109. If the female carer's account is accurate, in which she claims to only having been told of more details regarding Child AM's medical conditions at PMH on 22 June 2015, then I am of the view these significant details that were clearly going to impact on the level of care required for Child AM should have been disclosed at a much earlier stage. That responsibility rested with LWB. The female carer's account is that she was only advised of Child AM's global development delay, obstructive sleep apnoea and asthma when she met Child AM for the first time after her application to be the foster carer for Child AM was successful. All those medical conditions were outlined by the Department in its Placement Referral dated 1 May 2015.[47]

110. I note that LWB did provide the female carer with a copy of the Department's Placement Referral. However, it appears this was only done prior to the start of Child AM's placement with the female carer and her partner, and not before they made their application to care for Child AM. [48]

111. It is my view that whenever a child's care is regarded as complex there should always be sufficient disclosure of the child's medical and care needs to those potential carers who are considering an application to care for that child. Even if there are confidentiality requirements precluding the disclosure of the Department's Placement Referral at that stage, there should be some sort of summary of the major issues supplied by the service provider to prospective carers.

112. I highly commend the female carer's and her partner's commitment to look after Child AM, notwithstanding the challenges that existed. The following extract from the female carer's statement sharply brings into focus the magnitude of those challenges:[49]

> For the first month [Child AM] was waking up every 1-2 hours during the night.
>
> She had an obsession with food and would constantly look for it.

[46] Exhibit 1, Vol 1, Tab 12, Statement – Female carer dated 4 September 2015, [37]
[47] Exhibit 1, Vol 4, Tab 1.10, Placement Referral dated 1 May 2015, pp.3-4
[48] Exhibit 1, Vol 4, Tab 2, Statement – Ashley Daily dated 20 November 2020, [63]
[49] Exhibit 1, Vol 1, Tab 12, Statement – Female carer dated 4 September 2015, [50]-[60]

> I had a gate stopping her from getting into the kitchen.
>
> She would wake at night and start looking for food.
>
> She would barge the gates with her body weight to smash them down to get into the kitchen.
>
> I would hear the noise and wake up and stop her.
>
> She eventually learnt how to open the gates and one night she got into the kitchen. She was very quiet and we were all asleep.
>
> She ate [the male carer's] lunch for the next day – which was substantial.
>
> She also ate 7 Bella chocolate ice-creams, a jar of jam, a bowl of rice, cheese slices, a litre of milk, a can of diet coke, 2 yoghurts and some chocolate eclairs.
>
> She woke me up at 3:00 am that morning asking for me to open a packet of apple slices.
>
> It was so concerning that she could eat all of that in one sitting and not vomit and she still wanted more food.

113. I am satisfied that the information provided by the Department to LWB in 2015 regarding the second placement of Child AM was adequate. Having said that, I am also of the view that further information could have been provided. However, as I have already referred to, it is relevant that LWB had had previous contact with Child AM in 2014.

114. I also find that the training given to the female carer regarding the use of the BiPAP machine was not adequate. CAHS has conceded this training could have been done better.[50] However, I note that steps have been taken to improve this training. Steps have also been taken to improve communication between the Department and CAHS with service providers such as LWB. I have addressed those improvements later in this finding.

[50] Schedule to Oral Submissions by Mr Cade on behalf of the Department and CAHS, p.6

QUALITY OF SUPERVISION, TREATMENT AND CARE

By the various hospitals and other health providers

115. I have reviewed Child AM's medical files from CAHS, PMH and JHC.[51] I have considered the oral and written evidence with respect to the care provided by CAHS, PMH and JHC. I have also carefully reviewed the evidence and material relevant to the care extended to Child AM by other health providers; including the East Kimberley Clinic that Child AM attended, the Halls Creek Hospital and RDH.

116. I am satisfied that these hospitals' and the other health providers' supervision, treatment and care of Child AM was appropriate. The minor exception to that finding relates to the BiPAP training given to Child AM's female carer in June 2015 which I have already referred to. In general, I take no issue with Dr Bell's conclusion in her report that Child AM's medical care was "*excellent*". Dr Bell then stated her reasons for making that assessment:[52]

> [Child] AM was seen by services in Broome with thorough assessment and treatment on multiple occasions. Although not all notes from all of these admission have been made available to me, there is evidence through discharge summaries that there was thorough assessment of her multiple problems, and appropriate treatment was put in place. She was transferred to Perth, appropriately, for assessment and admissions when specialist service capacity in Broome was exceeded by the severity of her issues. At PMH she was assessed by paediatric staff with the following sub-specialist qualifications: respiratory, general paediatrics, cardiology, genetics, developmental, Aboriginal medicine, ENT, neurology, obesity, endocrinology and child protection. Her two PMH admissions were long, due to the need to see if she could lose weight, plus the need for many investigations, and also to arrange appropriate on-going community care. There are many instances of multi-disciplinary and multi-agency team meetings, to determine to [sic - the] best way forward for her care.

[51] Exhibit 1, Vol 2, Princess Margaret Medical File (this includes medical records from RDH); Exhibit 1, Vol 3, Tabs 1 and 2, Child and Adolescent Mental Health Service Acute Services File and Joondalup Health Campus Medical File
[52] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.9

> Her resuscitation at Joondalup Health proceeded as per protocol, following accepted resuscitation pathways without due delays or difficulties.

117. Although Dr Bell made a comment that, with the benefit of hindsight, it could be argued that earlier transfers to tertiary paediatric care at PMH which took place in May 2014 and again in April 2015 may have changed Child AM's management, I make no criticism of the timing of these transfers. As Dr Bell noted:[53]

> This, however, would have mandated earlier removal from her family and her culture. There is extensive evidence of consideration to the tension between these issues by medical, allied health and child protection staff at all locations. In retrospect, balanced, multilateral, informed decisions were made by interested parties. I cannot fault the timeline of decision making on review of the documentation. Additionally, I cannot see [Child] AM's ultimate outcome would have been different if the decision to remove her to PMH were made sooner.

118. Dr Wright expressed similar sentiments in her evidence at the inquest:[54]

> I can say that, as a general paediatrician, you know, my early involvement with her, she was thoroughly investigated. She had appropriate sub-specialist involvement and extensive support from allied health therapists, with communication with external organisations involved with her care.

By the Department

119. Throughout her time in the care of the Department's CEO, Child AM had five formal placements. She was initially brought into provisional protection and care from BRH where she had been admitted from 8 May 2014 until 23 May 2014. Her second placement was then with LWB carers in Perth from 23 May 2014 until 17 August 2014. Because of an interim placement order granted by Perth Children's Court, Child AM then resided with her maternal grandparents from 18 August 2014 until 3 January 2015. On that date she was admitted into DRH where she remained until her discharge on

[53] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.10
[54] ts 26.11.20 (Dr Wright), p.30

21 January 2015. Child AM was then placed in the provisional protection and care of the Department's CEO for the second time on 23 January 2015. However she then returned into her grandparents' care in Broome on 30 January 2015 where she remained until 6 April 2015 when she was transferred to PMH. Following her discharge from PMH on 29 June 2015, Child AM commenced living with LBW carers in Perth until her death on 4 September 2015.

120. It is very obvious that Child AM had complex support needs, particularly with respect to health, medical and behavioural issues. The Department became aware of those issues in June 2013. The SWA that the Department conducted in July 2013 concluded that medical neglect had not been substantiated. When making my assessment of the appropriateness of that conclusion I am mindful not to insert hindsight bias into that assessment.[55] What may be clear in hindsight is not often clear before the fact.

121. I am also mindful of the provisions of Section 12 of the Act which must be taken into account by the Department when determining the placement of a child under its care. That section reads:

> **12. Aboriginal and Torres Strait Islanders Child Placement Principle**
>
> (1) The objective of the principle in subsection (2) is to maintain a connection with family and culture for Aboriginal children and Torres Strait Islander children who are the subject of placement arrangements.
>
> (2) In making a decision under this Act about the placement under a placement arrangement of an Aboriginal child or Torres Strait Islander child, a principle to be observed is that any placement of the child must, so far is consistent with the child's best interests and is otherwise practicable, be accordance with the following order of priority –
>
> (a) placement with a member of the child's family;
>
> (b) placement with a child who is an Aboriginal person or a Torres Strait Islander in the child's community in accordance with local customary practice;

[55] Hindsight bias is the tendency after the event to assume the events are more predictable or foreseeable than they really were: *The Australasian Coroner's Manual,* Hugh Dillon and Marie Handley, 2015, p.10

(c) placement with a person who is an Aboriginal person or Torres Strait Islander person;

(d) placement with a person who is not an Aboriginal person or Torres Strait Islander but who, in the opinion of the CEO, is sensitive to the needs of the child and capable of promoting the child's ongoing affiliation with the child's culture, and where possible, the child's family.

122. Although the Department received further concerns for Child AM's health in early October 2013, it was not until 8 May 2014 that Child AM entered into the provisional protection and care of the Department's CEO. Notwithstanding that delay, and making sure I do not insert hindsight bias into my assessment, I am not satisfied that this delay was unreasonable or inappropriate. In so finding I have noted the following passages from the statement of Fiona Fischer, the Department's Regional Executive Director, Kimberley:[56]

> The Department's electronic records between 14 June 2013 and 8 May 2014 show that there were in excess of 126 contacts with health and family involved in the care and management of AM, consisting of a minimum of 92 contacts with medical staff and 34 contacts with family.
>
> During this same time, Departmental records indicate that the family were receptive and accepting of contact and support from the SCCPW [Senior Community Child Protection Worker].

123. I take no issue with the foster care placement that had been put in place by the Department and LWB following Child AM's discharge from BH on 22 May 2014. That arrangement was in place from 23 May 2014 until 17 August 2014. It is evident from the material before me that Child AM had made good progress when in this placement and although there was some behavioural issues, it is significant to note that her weight had been reduced by approximately 5 kg during this time.[57]

[56] Exhibit 1, Vol 1, Tab 8B, Statement – Fiona Fischer dated 4 March 2020, p.6
[57] Exhibit 1, Vol 1, Tab 8B, Statement – Fiona Fischer dated 4 March 2020, p.8

124. Although funding for this placement had been approved for six months,[58] on 17 August 2014 Child AM returned to live with her grandparents in Broome. That was because of the interim order made by the Perth Children's Court on 27 June 2014. Therefore this arrangement with the grandparents was out of the control of the Department.

125. With the considerable advantage of hindsight, a more appropriate course of action would have allowed Child AM to remain in the provisional protection and care of the Department's CEO and for the placement of Child AM with the LWB carers to continue. However, such hindsight was not available to the Perth Children's Court and one can readily appreciate why the interim order was made when regard is had to Section 12 of the Act.[59]

126. I am satisfied that notwithstanding it no longer had the care and protection of Child AM from 17 August 2014, the Department continued to monitor her wellbeing as much as possible whilst she was in the care of her grandparents. I am satisfied that this monitoring was appropriate, particularly when Child AM returned to live in the community in the East Kimberley sometime in November 2014. As already noted, this appeared to be contrary to the conditions in the interim order made on 27 June 2014. As referred to earlier, it would appear that this return to the East Kimberley community by Child AM had the consent of medical staff treating Child AM.

127. Nevertheless, by December 2014 the Department did have legitimate concerns regarding (i) Child AM's drastic weight increase whilst in the care of her grandparents and (ii) the fact that she had returned to the community in the East Kimberley to live for longer than the two week trial period that had previously been discussed. However, I can appreciate why those concerns may have been allayed by the email the Department received on 31 December 2014 from the Senior Regional Paediatrician for the Kimberley. I have already cited the contents of this email earlier in my finding and noted that it stated Child AM had been medically stable for some time and that she was being looked

[58] Exhibit 1, Vol 1, Tab 8B, Statement – Fiona Fischer dated 4 March 2020, p.8
[59] This factor was noted by Mr Geddes during his evidence at the inquest: ts 26.11.20 (Geddes), p.78

after by clinic staff at the East Kimberley community where she was residing.

128. Three days after this email Child AM was evacuated from the community by the RFDS and admitted to RDH in a serious condition. Less than four weeks later Child AM was placed in the provisional protection and care of the Department's CEO for a second time.

129. Although the reason for the Department seeking the provisional protection and care was because Child AM had been medically neglected when in the care of her grandparents, she returned to live with those same grandparents in Broome following her discharge from RDH. When questioned at the inquest why this placement was made, Mr Geddes gave explanations for that decision.[60] Essentially, the decision was based on the preference of having Child AM reside with her family in a known environment with access to the required medical care rather than removing her down to Perth and placing her in foster care.

130. After careful consideration, I find that decision by the Department was appropriate; particularly when regard is had to the provisions of Section 12 of the Act. I am also satisfied that the Department's oversight of Child AM during this time was appropriate.

131. Notwithstanding the efforts by the Department to keep Child AM with family and close to medical facilities to address her health concerns, she was admitted again to PMH on 6 April 2015 where she remained for nearly three months. I find that it was appropriate for the Department to place Child AM in foster care in Perth on 29 June 2015 following her discharge from PMH. It was clear by then that the medical facilities in Broome were not going to be adequate to treat Child AM's various medical conditions. It was also imperative she was in an environment that would be the most conducive to continuing the significant weight loss that she had achieved while admitted to PMH.

[60] ts 26.11.20 (Geddes), pp.81-82

132. By August 2015 it became evident to LWB that its tender for the cost of Child AM's care had been underestimated to a considerable degree. It had made no allowance for respite care and it had already spent the bulk of its 12 month budget for Case Support Costs.[61] By letter dated 17 August 2015 to the Department, LWB sought variations of the current costings for the first six months of Child AM's care and provided a revised itemised breakdown of its costs.[62] Officers from the Department were verbally supportive of the variation seeking further respite care.[63] However, no written response had been obtained from the Department prior to Child AM's death.

133. I also note that in August 2015 the Department began arrangements for Child AM to have contact with her family through video link facilities at the clinic in the East Kimberley community where her family resided.[64] That was a very appropriate measure to take.

134. Although I am satisfied as to the adequacy of the supervision, treatment and care provided to Child AM by the Department, I do note the following apparent[65] concession made by Mr Cade in the schedule to his oral submissions handed up at the inquest: "*However, the fact that improvements have been recognised and implemented did diminish the quality of supervision, treatment and care provided to Child AM by the (now) Department of Communities.*"[66]

135. Those improvements that have been made by the Department (and also LWB and CAHS) are considered below.

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[61] Exhibit 1, Vol 4, Tab 1, Statement – Roderick Best dated 20 November 2020, p.9
[62] Exhibit 1, Vol 4, Tab 2.60, Letter from LWB to the Department dated 17 August 2015
[63] ts 26.11.20 (Daily), p.108
[64] Exhibit 1, Vol 1, Tab 8B, Statement – Fiona Fischer dated 4 March 2020, p.13
[65] By letter dated 11 June 2021 to the court, and after a copy of my Finding was provided to Child AM's family, Mr Cade advised that he had inadvertently omitted a word in the sentence I have quoted from his schedule to his oral submissions. The sentence was supposed to include the word "not" between "did diminish". He therefore did not intend to make the concession.
[66] Schedule to Oral Submissions by Mr Cade on behalf of the Department and CAHS, p.4

IMPROVEMENTS SINCE CHILD AM'S DEATH

By the Department

136. The Department has initiated a number of practice improvements since the death of Child AM. As would be expected of all governmental departments, the Department should always be on a pathway of continual improvement. I commend these improvements which were set out in Ms Fischer's statement and included the following:[67]

- In 2016, the East Kimberley District recruited a permanent Aboriginal Practice Leader to support cultural planning and assessment.

- In 2016, the Department developed the *Building Safe and Stronger Families: Early Intervention and Family Support Strategy*. This strategy is aimed at implementing processes to work more intensively with children and families with significant child protection concerns and a state-wide initiative of working with Aboriginal families earlier and in a culturally competent way. It is conducted in partnership with community organisations.

- In August 2017, a Senior Field Worker – Aboriginal Intensive Family Support position was created and filled in the East Kimberley District that had a specific role to support Intensive Family Support teams to provide culturally appropriate and inclusive family support practice.

- In 2017, the Department implemented a Central Intake Model to improve the consistency of decision-making in relation to the assessment of notifications of concern for a child. Incorporated into this model was a new decision-making tool known at the "*Interaction Tool*". A "*Risk Score*" of 5 or above will result in a recommendation to intake the case. The Kimberley region commenced the use of the Interaction Tool in late 2018 following training and state-wide implementation.

[67] Exhibit 1, Vol 1, Tab 8B, Statement – Fiona Fischer dated 4 March 2020, pp.13-18

- In August 2017, the Department implemented a new *Child Protection Learning Pathway*. This program is mandatory for new staff and provides a standardised framework for undertaking child protection practices.

- In June 2018, contracts for Intensive Family Support services were awarded in the East and West Kimberley regions. These services commenced in September and October 2018.

- In July 2019, the Department commenced a review of the SWA process to consider ways to promote critical thinking and increase consistency of processes and outcome reports.

137. Although not all of these measures have been introduced as a direct result of Child AM's death, I commend the Department's efforts to improve its practices and procedures in these areas.

By LWB

138. In 2017 a Clinical Governance Partner undertook a preliminary review of material provided to it by LWB. It found "*variation and inconsistent practice*" across LWB locations and programs.[68] These included:[69]

- Terms of Reference for Higher Risk and Restricted Practice Panels;

- Identification and definition of higher risk clients;

- Panel membership;

- Record and information management;

- Reporting requirements;

- Monitoring outcomes and follow-up.

139. The measures put in place to address these areas by LWB is encouraging. The concept of a Complex Support Needs Panel for on-

[68] Vol 1, Exhibit 4, Tab 1.13, Overview Complex Needs Panels – October 2018, p.6
[69] Vol 1, Exhibit 4, Tab 1.13, Overview Complex Needs Panels – October 2018, p.6

going monitoring and support of those persons that LWB is providing support to who have "*complex"* medical and/or clinical needs is a sound one.[70]

140. Following Child AM's death, the Department collaborated with LWB to strengthen the inter-agency management of children placed in out-of-home care with complex health and care needs.[71]

141. In April 2019, LWB reported to the Department on its implementation of the following Continuous Improvement Strategies: [72]

- iSight: In December 2017, LWB introduced iSight to address inconsistencies in reporting and capturing critical incidents. iSight generates an automatic template and therefore assists with a quick and accurate reporting system to the Department. It provides benefits to working with children with the care needs like Child AM's as it facilitates the identification by management of significant trends of the child's care from data obtained from carers or respite carers.

- Carer Agreements: LWB reviewed and updated its carer agreements to align with its service agreements with the Department, streamlining the process for carer reviews.

- Child Safety and Wellbeing: LWB developed Guidelines and a Flowchart illustrating the process for responding to concerns raised for the safety and wellbeing of children in care. This process included internal and external reports, meetings, actions and correspondence with the carer

- Feedback and Engagement Strategy: LWB developed and implemented a range of documents outlining the various ways in which clients, carers and families could provide quicker feedback on the services provided by LWB.

[70] Vol 1, Exhibit 4, Tab 1.13, Overview Complex Needs Panels – October 2018, p.15
[71] Exhibit 1, Vol 1, Tab 8C, Report – Lindsay Hale dated 15 April 2020, p.4
[72] Exhibit 1, Vol 1, Tab 8C, Report – Lindsay Hale dated 15 April 2020, p.4; Exhibit 1, Vol 4, Tab 1, Statement – Roderick Best dated 20 November 2020, p.8

- Safety Plans with Carers: As from April 2019, LWB has developed safety plans with carers to address acute needs and behavioural concerns of children. This includes providing external and internal training to staff and carers in such areas as First Aid, positive behaviour support and therapeutic crisis intervention.

By CAHS

142. It is clearly evident from the material before me that Child AM's use of the CPAP and BiPAP machines was less than optimal. That is unsurprising given her age. Dr Wilson made the point that:[73]

> We know that long-term adherence to the use of this equipment is poor and that only about 50% of users of the equipment can manage to use it as recommended. Tolerance of the equipment is particularly poor in children under four years of age.

143. In 2015 the CPAP and BiPAP machines that were in general use were able to store data. However, they were not capable of remote monitoring. This meant medical staff could only access the data from these machines if they were brought into the hospital where the data could be downloaded from a memory chip within the machine.[74]

144. The problem with this arrangement arose in Child AM's care shortly before her death. Her CPAP machine was not brought in for an appointment at PMH on 1 September 2015 (four days before her death). No data was therefore available regarding compliance.[75] Dr Wright noted that when the CPAP machine was returned after Child AM had died, it showed that the machine had only been used for 22 of the previous 90 days and for only three days was it used in excess of four hours. The daily average use over those 22 days was 1.9 hours.[76] I agree with Dr Wright's assessment that "*this clearly showed the usage was inadequate*."[77] This was information that was clearly important for medical staff treating Child AM to know. In making that observation I wish to stress that this is not a criticism of

[73] Exhibit 1, Vol 1, Tab 20, Statement – Dr Andrew Wilson dated 25 November 2020, p.5
[74] Exhibit 1, Vol 1, Tab 20, Statement – Dr Andrew Wilson dated 25 November 2020, p.4
[75] Exhibit 1, Vol 1, Tab 10B, Report – Dr Helen Wright dated 10 May 2016, p.1
[76] Exhibit 1, Vol 1, Tab 10B, Report – Dr Helen Wright dated 10 May 2016, p.1
[77] Exhibit 1, Vol 1, Tab 10B, Report – Dr Helen Wright dated 10 May 2016, p.1

Child AM's carers at that time. It is clear from other material before me that it was extremely difficult to have Child AM comply with the wearing of the CPAP machine for the recommended four hours every night.[78]

145. A Critical Incident Review Panel made recommendations as to how foster families could be better supported when dealing with complex patients such as Child AM. The improvements that have now been introduced include the following: [79]

- The CPAP and BiPAP machines now in general use at Perth Children's Hospital (PCH) are capable of remote monitoring which means they are capable of sending data via a wireless network from wherever they are. This data is stored at PCH and is reviewed at least weekly by a specialist respiratory nurse. Any concerning indications are brought to the attention of the respiratory team.

- Those CPAP and BiPAP machines that are still being used without remote monitoring are not used for patients who are being introduced to the use of this equipment or for high risk patients.

146. Another measure that has been introduced is the creation of a Positive Pressure Initiation Clinic. All patients and their carers who are being initatied into the use of CPAP or BiPAP machines are trained in the use of the equipment at this clinic.[80] A further change that has been introduced since 2015, is that it is no longer usual for the carer to stay overnight at the hospital to have the use of the equipment demonstrated to them.[81]

147. PCH has also introduced improvements in the support provided to carers of complex patients. These improvements were set out by Dr Wilson as follows:[82]

[78] Exhibit 1, Vol 1, Tab 10D, Statement – Dr Helen Wright dated 19 November 2020, pp.2-3
[79] Exhibit 1, Vol 1, Tab 20, Statement – Dr Andrew Wilson dated 25 November 2020, p.4
[80] Exhibit 1, Vol 1, Tab 20, Statement – Dr Andrew Wilson dated 25 November 2020, p.4
[81] Exhibit 1, Vol 1, Tab 20, Statement – Dr Andrew Wilson dated 25 November 2020, p.5
[82] Exhibit 1, Vol 1, Tab 20, Statement – Dr Andrew Wilson dated 25 November 2020, p.6

> It was also recognised that foster carers who are taking care of a child with complex needs for the first time require more additional support than other carers. First time carers are generally not aware of the full complexity of a child's health care and do not have any prior experience in caring for the child.
>
> A checklist has now been developed to ensure patients and carers are properly educated about the use of CPAP and BiPAP equipment.
>
> A video has also been prepared to help educate patients and carers in the use of CPAP and BiPAP equipment.
>
> Other improvements as to how PCH better supports carers of complex patients include the Connect Care programme for kids, launched [last] year, a care coordination program for children with long term medical complexity which aims to help families navigate health and disability services by providing family-focused care coordination. These services included discharge planning, development of health care plans, education and telephone support.

148. I commend CAHS for its introduction of these improvements since 2015. I would also strongly urge CAHS to consider the two recommendations offered by Dr Rae-Chi Huang, a paediatric consultant at PCH. They were (i) an outreach service for paediatric respiratory that provides support and ensures compliance with CPAP and BiPAP machines and (ii) training to rural child health nurses, families and foster carers who are involved with such machines that are critically needed for children with the type of medical conditions that Child AM had.[83]

RECOMMENDATIONS

149. Given the gap between the date of a death requiring a mandatory inquest and the date of the inquest, those governmental departments and entities connected to the death will often implement changes before the inquest is heard that are designed to improve practices and procedures with the aim of preventing similar deaths in the future. As

[83] Exhibit 1, Vol 1, Tab 18, Report – Dr Rae-Chi Huang dated 5 November 2020, pp.5-6

outlined above, there have been a number of changes and improvements since Child AM's death nearly six years ago.

150. In her closing submissions, Ms Lendich submitted I could make a recommendation that there be better collaboration between the service providers (particularly with those providing medical treatment) that are involved in the care of a child with the level of complex needs that Child AM had.[84]

151. Based on all the evidence before me and considering the changes that have already been made, I do not see the merit in making such a broad-brush recommendation. Every matter will need to be considered on a case-by-case basis and I would expect that if input was required from any health provider who is involved in the treatment of a child in the care of the Department's CEO, then the necessary arrangements would be made.

The Addressing of Childhood Obesity

152. As already detailed, Child AM had a number of major complications arising from her significant obesity. The number of children classified as being either overweight or obese in Australia is growing and has now become a matter that should be of major concern. As stated by Dr Bell:[85]

> The 2016 National Health Survey estimates that 26% of Australian children 5-17 years are overweight (19%) or obese (7.1%). Paediatric obesity is known to be associated with serious physiological and psychological comorbidities and these complications are occurring at early ages. These comorbidities include insulin resistance, high cholesterol, hypertension, type 2 diabetes, obstructive sleep apnoea, non-alcoholic fatty liver disease, depression and anxiety. The current disease burden in these children and the future disease burden of their progression to obese adults represents significant financial and socio-economic costs to the community. Weight loss can minimise or reverse these health problems and improve the long term health prospects for the child.
>
> …

[84] ts 26.11.20 (Closing Submissions by Ms Lendich), p.136
[85] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.1

> Due to the increases in obesity in genetically stable populations, much of the childhood obesity epidemic can be attributed to adverse environmental factors, lifestyle, and culture. This includes increases in calorie, sugar and fat intake, increased portion size and a steady decline in physical activity globally.

153. I agree with Dr Bell's description that we now have a "*childhood obesity epidemic*" amongst our children.

154. Western Australia's only paediatric obesity service is located in Perth at PCH. When it was at PMH this service was known as CLASP. At PCH it is now known as Healthy Weight Service (HWS). In my view, this is an essential service as weight loss can reverse, or at the very least, minimise the health problems related to obesity. This, in turn, will improve the long-term health prospects of children.

155. HWS is located at the Endocrinology Department at PCH. It is a multi-disciplinary tertiary obesity clinic aimed at lifestyle change and management of obesity-related comorbidities for children aged 16 years and under. It consists of specialised clinicians which include paediatricians, nurses, dieticians, social workers, physiotherapists and psychologists. As stated in Dr Bell's report:[86]

> Holistic outpatient-based lifestyle intervention programs, aimed at behaviour change for the whole family, are available to eligible, motivated families. The management of significant and complicated obesity requires intensive lifestyle education and support over substantial periods of time. The program has demonstrated success in reducing the weight and health risk in participants.

156. However, HWS (as its predecessor CLASP was) is an outpatient only service. It has no inpatient capacity.

157. Neither is there a HWS outreach service. This lack of an outreach service concerns me. As explained by Dr Bell:[87]

> This means that those children in WA living outside the Perth metropolitan area cannot access this clinic unless there is travel supported by PATS [Patient Assisted Travel Scheme]. This is often not feasible due to the

[86] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.12
[87] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.12

> frequency of appointments and reviews needed for intensive lifestyle change and support needed in obesity management. Local rural/remote services are therefore engaged (e.g. dietician, physiotherapist, GP, Aboriginal Health Workers). However, local staff may not have the skills to manage such severe cases. There is no staff up-skilling program from PCH to rural/remote staff for paediatric obesity. Currently, phone support from HWS staff is given ad-hoc to remote locations where local staff are trying to manage severe cases. Telehealth is currently being trialled but does not allow physical examination by the HWS doctor, nor direct assessment by the HWS physiotherapist.

158. The recommendation for an outreach arm of HWS is also supported by Dr Huang, who is employed as a paediatric consultant in a part-time role at HWS. In her report, Dr Huang stated:[88]

> This recommendation would have benefits in preventing similar cases as [Child] AM. This would include providing education and intermittent outreach clinics to remote areas, supplemented with telehealth.
>
> A cost-effective way of reaching large parts of our state's smallest and sparest remote areas, may be a videoconferencing program to provide education and access to specialist advice for health care workers in regional and remote WA. This collaborative model of medical education and case management would allow for evidence-based care to be provided within the community to a specialist standard. The PCH Healthy Weight Service estimates that such a program could be set up for $220,000 start up costs and $70,000 per annum ongoing costs.
>
> These initiatives are likely to be feasible if done in strong in [sic] partnership with services on the ground in rural or remote regions.

159. I fully endorse this proposal by Dr Lee and Dr Huang. Children with significant weight issues should not be denied access to such an important service that HWS offers simply because they live in a rural or remote location.

[88] Exhibit 1, Vol 1, Tab 18, Report – Dr Rae-Chi Huang dated 5 November 2020, p.5

Recommendation No. 1

In order to address childhood obesity in remote and regional areas, I recommend the Western Australian government considers introducing an outreach service for the Healthy Weight Service Clinic at Perth Children's Hospital.

160. I also propose making another recommendation that is aligned with the recommendation above. Dr Bell's report referred to a review of the CLASP program in 2015 that highlighted the need to adapt the program so that it became culturally appropriate for Aboriginal families. Components of the original program were then modified to have a more Aboriginal focus that acknowledged the diverse nature of communities and the varying abilities to read and understand concepts. This model began operating as a pilot program in mid-2015. Dr Bell reported that it had, "*success and positive behaviour change and demonstrated feedback from Aboriginal consumers*."[89] However, notwithstanding that success, the program was not funded past early 2017 and there remains no directly funded Aboriginal staff input into HWS as of June 2019.[90]

161. In order to ensure that my first recommendation is effective for Aboriginal families in remote locations, it will be necessary that the program be culturally appropriate for Aboriginal families. Accordingly, I make the following recommendation;

Recommendation No. 2

In order for the program offered by the Healthy Weight Service Clinic to be culturally appropriate for Aboriginal families, I recommend that the Western Australian government considers reintroducing, on a permanent basis, the pilot program offered by the Healthy Weight Service Clinic from mid-2015 to early-2017.

[89] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.13
[90] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.13

162. There were other suggestions made by Dr Bell that she believes would prevent future deaths similar to that of Child AM. Those proposals are also highly commendable, in particular the need for further education amongst general practitioners about antenatal and early childhood obesity prevention. Such increased education would see a rise in the number of early tertiary referral for intervention in cases of childhood obesity.[91]

163. I also agree with Dr Bell's evidence at the inquest that there must be an increased education in the general community regarding the dangers of childhood obesity, otherwise "*without a community response and a community appreciation of this as a medical issue rather than a social issue, we're not likely to make much progress*".[92]

CONCLUSION

164. Child AM was clearly a much loved child amongst her family and those who had provided her with out-of-home care.

165. Unfortunately, Child AM struggled with obesity for most of her short life. Despite the very best intentions of her family, her out-of-home carers and the many health providers who treated her complex medical conditions, she died of bronchopneumonia 11 days before her fourth birthday.

166. Child AM was placed into the provisional protection and care of the Department's CEO from 8 May 2014 until 17 August 2014 and again from 30 January 2015 until her death on 4 September 2015. I am satisfied that the supervision, treatment and care provided by the Department to Child AM was appropriate. Nevertheless, the Department (as well as LWB and CAHS) have made a number of changes to their procedures and practices in their endeavours for continual improvement. They are to be commended for making those changes.

[91] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.13
[92] ts 26.11.20 (Dr Bell), p.69

167. The evidence at the inquest brought into sharp focus the significance of Child AM's obesity in her tragic death. The statistics relating to the high level of childhood obesity in Australia is alarming. As noted by Dr Bell:[93]

> After reading [Child] AM's case, it seems that a perfect storm of known factors aligned, and were at play in her untimely death, including international, community, cultural, socio-economic, genetic, biological and behavioural influences. Her case reads as an instructive to health care professionals, community workers, childcare workers, teachers, parents, policy makers and politicians, as to the multifactorial nature of obesity, and the co-ordinated, multi-level, approach we need as a society to combat it.

168. I have made two recommendations aimed at addressing the childhood obesity that is becoming increasingly prevalent in our society. However, those recommendations will only go a very small way in addressing the problem of childhood obesity that now requires society to conduct a "*co-ordinated*, *multi-level approach*" to address it. To cover all the matters raised by Dr Bell in that part of her report quoted above was beyond the scope of this inquest. Nevertheless, it is my hope that these recommendations, and the changes already made by the governmental departments and service providers such as LWB following Child AM's death, may provide some small consolation to her family for their tragic loss.

P J Urquhart
Coroner
22 June 2021

[93] Exhibit 1, Vol 1, Tab 11, Report – Dr Lana Bell dated 17 June 2019, p.1

Annex A

Abbreviation	Meaning
AACC	Aboriginal Ambulatory Care Coordination
The Act	*Children and Community Services Act 2004* (WA)
AHT	Aboriginal Health Team
BiPAP	Bi-level Positive Airway Pressure
BH	Broome Hospital
CAHS	Children and Adolescent Health Service
CEO	Chief Executive Officer of the Department of Child Protection and Family Support
CLASP	Changes in Lifestyle are Successful in Partnership
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary Resuscitation
CPU	Child Protection Unit
CT	Computerised Tomography
The Department	The Department of Child Protection and Family Support (now the Department of Communities)
JHC	Joondalup Health Campus
ECG	Echocardiogram
EEG	Electroencephalogram
HWS	Healthy Weight Service
KHR	Kimberley Health Region
LWB	Life Without Barriers
MRI	Magnetic Resonance Imagery
PCC	Paediatric Cardiology Clinic
PCH	Perth Children's Hospital
PMH	Princess Margaret Hospital
RDH	Royal Darwin Hospital
RFDS	Royal Flying Doctor Service
SWA	Safety and Wellbeing Assessment