JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	:	12-13 JANUARY 2021
DELIVERED	:	16 APRIL 2021
FILE NO/S	:	CORC 26 of 2017
DECEASED	:	Child LDW

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Tyler assisted the Coroner.
Ms K Ellson (SSO) appeared on behalf of the Department of Communities.

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Child LDW*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 12 January 2021 - 13 January 2021, find that the identity of the deceased person was* ***Child LDW*** *and that death occurred on 14 August 2017 at 6 Moore Street, Wongan Hills, from tramadol toxicity in the following circumstances:*

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SUPPRESSION ORDER

The deceased's name is suppressed from publication. The deceased should be referred to as Child LDW in any external publication and no information should be published that might lead to the identification of the deceased.

INTRODUCTION

1. Child LDW, who I will refer to as the deceased in this finding, was born on 2 September 2013 and died on 14 August 2017, a couple of weeks short of her fourth birthday. At the time of her death, the deceased was a person held in the care of the Chief Executive Officer of the Department of Communities under a Time Limited Protection Order that was in place until 27 March 2019. She had been taken by the Department from her mother's care for safety reasons and was temporarily living with her step-father, Mr Hine,[1] and her three siblings in a home in Wongan Hills.

2. The deceased was found unresponsive and lifeless in her bed by her step-father at 2.30 pm on 14 August 2017. He drove her to Wongan Hills Hospital, where her death was confirmed. Initially it was unclear what had caused her death, so it was an unexplained death, but it was not immediately treated as suspicious.[2]

3. However, a post-mortem examination found the deceased died as a result of tramadol toxicity. Tramadol is an opioid medication used to treat pain and was prescribed to the deceased's step-father. The cause of death prompted the WA Police Homicide Squad to launch a full criminal investigation into the circumstances of the deceased's death. Mr Hine was interviewed as a suspect as part of that investigation. At the end of the investigation the police could not exclude the possibility that the deceased had found the tramadol and taken it herself. Accordingly, no person was charged in relation to the death.

4. As the deceased was in the Department's care when she died, a coronial inquest is mandatory and I must comment on her care, treatment and supervision prior to her death.[3]

5. I held an inquest at the Perth Coroner's Court on 12 and 13 January 2021. The inquest focussed particularly on how the deceased came to ingest the fatal quantity of tramadol and, in that context, the quality of her overall supervision, treatment and care by the Department.

6. The police investigation into the death included interviews with many members of the deceased's family, including her siblings, and that material was before me by way of statements and recorded interviews. I also heard oral evidence from a number of experts in relation to the cause of death, as well as staff from the Department who were involved in the deceased's care. The deceased's step-father, Mr Hine, who was caring for the deceased at the time of her death, also gave evidence at the inquest.

7. At the conclusion of the inquest, I noted that I was likely to make some adverse comments against Mr Hine to the effect that he didn't provide a safe home for the deceased. There is no evidence he deliberately caused her death, but he left out dangerous medications that he knew he ought to have kept safely out of reach of the younger children in a locked cabinet.

8. The finding that Mr Hine failed to provide a safe home environment has relevance to the Department of Communities, as he was their approved carer for the deceased. Some concerns had been raised by the children's mother and grandmother about his suitability to care for the children safely and those concerns were not acted upon in a timely way. It should have been apparent that Mr Hine was not coping and needed more support, but nothing urgent was done to reassess his suitability as a carer or visit his home or provide any additional support to him. There are reasons for that, which I consider further in this finding, but I simply note at this stage that there was a failure on the part of the Department of Communities to act quickly to ensure

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[1] He was technically not her step-father, as he had not been married to the deceased's mother, but he certainly took on that *de facto* role and is the father of two of her siblings, so I will refer to him as such.
[2] T 14.
[3] Pursuant to sections 3 and 22(1)(a) *Coroners Act* the death is deemed to be a 'death in care'.

that Mr Hine was providing a safe environment for the deceased to live in prior to her death. If more had been done to investigate the concerns of the mother and grandmother, it is possible that the deceased's tragic death could have been prevented.

BACKGROUND

9. The deceased was the daughter of KD and BW. She was born very premature at 27 weeks on 2 September 2013 and weighed only 828 grams at birth. Her mother admitted to having regularly used cannabis and methylamphetamine while the deceased was in utero.[4] The deceased suffered from chronic lung disease as a result of her prematurity. At 12 months of age she was assessed by a developmental paediatrician at King Edward Memorial Hospital, who noted the deceased was showing a marked overall delay, particularly in the area of gross motor skills. However, her development improved from that time, and at the time of her death her gross motor skills were considered to be normal for her age.[5]

10. The deceased had an older brother, SD,[6] who was born a couple of years earlier. The deceased also had two older half siblings, a sister AHD[7] and brother JHD,[8] who were born to her mother KD and her previous partner, Mr Hine. After Mr Hine and the deceased's mother separated in 2009, they continued to live together in the same family home for many years, even after the deceased's mother began a new relationship with BW in 2011. Mr Hine continued living with the deceased and her extended family until 2015, after which he moved out to his own home. The evidence indicates there was friction with KD's new partner that prompted the move.

11. The relationship between the deceased's biological parents, KD and BW, was marred by domestic violence. Between 2011 and 2016 there were 24 family and domestic violence incidents reported involving the couple and KD had taken out a number of Violence Restraining Orders against the deceased's father, many of which were breached. The deceased's father was also imprisoned a number of times during this period, and was incarcerated at the time of the deceased's birth.[9]

12. The Department had considerable involvement with the deceased's extended family over the years, often due to the violence and breached VRO's but also due to allegations of neglect of the children. The first involvement specifically related to the deceased was on 9 April 2015, when the Department received a report that the deceased (who was then 17 months old) had been found on the road without supervision. The following day Department staff conducted an unannounced home visit and found the deceased's brother SD (then three years old) naked out the front of the home. The deceased's mother was spoken to and she spoke about her difficulties in managing the children and the limited support she received from Mr Hine, stating that he was "always doped up on medication for his sore back."[10] The matter was progressed by the Department as there were concerns in relation to the children being neglected.[11]

13. On 6 May 2015 the Department received a report that KD was regularly using methylamphetamine, which was impacting on her care and supervision of the children. Enquiries were made with the older children's school and then a home visit was conducted on 20 May 2015. KD denied illicit drug use, other than cannabis, and advised she felt overwhelmed but she did not wish to put the deceased into daycare or the deceased's brother into kindergarten.

[4] Exhibit 2, Tab 1, SC82, p. 6 and Tab 14 [115] – [116].
[5] T 13; Exhibit 1, Tab 9, pp. 7 – 8 and Tab 21
[6] I will refer to him as the deceased's brother to distinguish him from other siblings.
[7] I will refer to her as the deceased's half-sister to distinguish her from other siblings.
[8] I will refer to him as the deceased's half-brother, to distinguish him from other siblings.
[9] Exhibit 1, Tab 12A, p. 2.
[10] Exhibit 1, Tab 12A, p. 5.
[11] Exhibit 1, Tab 12A.

The deceased's father was still in prison at this time but KD indicated her intention to maintain her relationship with him upon his release. Support services were put in place and on 29 July 2015 the neglect complaint in relation to the deceased from the April event was found to be unsubstantiated and the case was closed.[12]

14. On two occasions, in July 2015 and again in August 2015, Mr Hine contacted the WA Police and the Department of Communities after arguments with the deceased's mother. He expressed a concern she was using methylamphetamine and not providing suitable care for the children. Mr Hine advised the Department he was making plans to move to the Wheatbelt and wished to take his two biological children, JDH and ADH, with him. He was advised to seek legal advice.[13]

15. From August 2015 until 25 March 2016 the deceased and her siblings were cared for by KD, with the support of the deceased's maternal grandmother, LD.[14]

16. On 23 September 2015 WA Police raised concerns with the Department of Communities for the welfare of the children, following another report from Mr Hine that KD was using drugs, being physically and verbally abusive towards the children and residing in an unfit and unsafe environment. He provided voice recordings and photos in support of his claims. Mr Hine also obtained a VRO against KD on the same day. The Department commenced an inquiry into the allegations.[15]

17. On 17 November 2015 Department staff conducted a home visit at KD's property and noted both the deceased and her brother appeared unclean. KD advised that she was struggling to manage the children since Mr Hine had left and indicated she would welcome support. She also indicated that she was concerned about BW's impending release from prison in January 2016. She feared violent repercussions if she denied him access to the house.

18. On 5 December 2015 the WA Police notified the Department's Crisis Care Unit that they had attended KD's house following a report that KD had physically assaulted her daughter AHD. Crisis Care staff attended the house and noted KD was difficult to engage and her pupils appeared to be dilated. She admitted regular use of cannabis and stated she had taken prescription pain medication that day. They discussed her former relationship with Mr Hine and KD advised he had never been violent towards her, unlike her other partners, and she only ended the relationship with Mr Hine as her other relationships were 'more exciting'.[16] KD stated she had not been coping with the children since Mr Hine left and admitted to using tabasco sauce and then pepper to discipline them. KD agreed to a safety plan proposed by the Department in relation to the children.[17]

19. On 8 December 2015 Mr Hine advised the Department that he had obtained a house in Dowerin and he was being supported by Legal Aid and a local support agency in family court proceedings relating to his two children with KD. He also advised he had not had contact with KD since the VRO against KD came into force on 25 September 2015.[18]

20. On 10 December 2015 the Department received another report KD was using methylamphetamine. Staff attended the home and found the deceased naked and alone in the front yard behind a secured gate. During the visit KD was seen repeatedly hitting the deceased's brother, SD, only stopping when the Department's workers intervened. On the same day the

[12] Exhibit 1, Tab 12A.
[13] Exhibit 1, Tab 12A.
[14] Exhibit 1, Tab 12A.
[15] Exhibit 1, Tab 12A.
[16] Exhibit 1, Tab 12A, p. 7.
[17] Exhibit 1, Tab 12A, p. 7.
[18] Exhibit 1, Tab 12A, p. 8.

deceased's half-brother JHD participated in a Child Assessment Interview and made a number of disclosures about KD using substances and putting pepper in the children's mouths. He also disclosed Mr Hine had yelled at him when he still lived in the family home.[19]

21. On 23 December 2015 the WA Police again made a report to the Crisis Care Unit after it became known that KD had gone to hospital with her daughter AHD in the early hours of the morning and left the younger three children at home unsupervised. Police stayed at the home with the children until KD was discharged from hospital later that morning. Department staff attended the house that day and found the deceased and her brother naked in the yard and noted KD appeared unwell and frail. KD was hospitalised a few days later with gastritis.[20]

22. On 7 January 2016 a clinical psychologist from the Child and Adolescent Mental Health Service, who had assessed the two older children, found that both AHD and JHD's behavioural issues resulted from KD's parenting and it was felt they would improve if the home environment improved.[21]

23. On 8 January 2016 the Department held a Signs of Safety meeting with KD and her mother LD and Wanslea staff were also in attendance. KD agreed to place the deceased in daycare when her father, BW, was released from prison and she also agreed to report any violence from BW to the Police.[22]

24. On 15 January 2016 the Department finalised its investigation and substantiated the likelihood of emotional and physical harm for the deceased, and her brother and two other siblings due to KD's use of inappropriate discipline. The family were referred for support.[23]

PLACEMENT WITH STEP-FATHER

25. On 18 January 2016 the Family Court of Western Australia received a Notification of Child Abuse or Family Violence filed by Mr Hine in relation to his biological children, AHD and JHD. The accompanying affidavit also included information in relation to the deceased. On 19 January 2016 the Court informed the Department that Mr Hine was seeking an urgent recovery order in relation to AHD and JHD and sought the Department's view. The Department provided information to the Court about its recent finding regarding excessive discipline and also reported concerns regarding KD's alleged drug use, history of family and domestic violence, lack of supervision and BW's impending release from prison. The Court apparently ordered that BW was only to attend KD's house when AHD and JHD were not present.[24]

26. On 9 February 2016 Department staff conducted a home visit at KD's home and KD advised she was working with Wanslea on her parenting issues and did not require further support.[25] There were escalating issues with AHD's behaviour later that month and KD admitted she used pepper to discipline her again. There were ongoing issues throughout March 2016, including concerns raised by WA Police about possible neglect of the children and violence between KD and BW. Wanslea staff contacted the Department to report an observed decline in KD's mental health and staff concerns that it was not clear she had the capacity to make the necessary changes to her parenting. The Wanslea staff expressed specific concern for the children's safety when their maternal grandmother, LD, was not present.

[19] Exhibit 1, Tab 12A, p. 8.
[20] Exhibit 1, Tab 12A, p. 9.
[21] Exhibit 1, Tab 12A, p. 9.
[22] Exhibit 1, Tab 12A, p. 9.
[23] Exhibit 1, Tab 12A, p. 9.
[24] Exhibit 1, Tab 12A, p. 10.
[25] Exhibit 1, Tab 12A, p. 10.

27. On 23 March 2016 Department staff conducted a home visit and saw signs KD was under the influence of substances and evidence suggesting there were safety concerns for the children. Their grandmother, LD, also reported concerns for the children's wellbeing but informed the Department staff she could not remain in the home as she was in conflict with KD. LD advised she was not in a position to care for the children full-time, although she was willing to support Mr Hine to care for all four children. She informed Departmental staff that the deceased's brother, Mr Hine's step-son, called Mr Hine 'Dad' and visited him on weekends with Mr Hine's biological children.

28. Staff from the Department advised KD and LD they would hold an internal Signs of Safety meeting the next day, to assess the safety of the children given these concerns, and requested their attendance. KD did not attend the meeting. The children were assessed as being at immediate and substantial risk of harm and the District Director provided approval for the deceased, SD, JHD and AHD to be brought into the provisional protection and care of the CEO. Department staff spoke to Mr Hine and it was reported that he agreed to care for all four children, if required, to allow the siblings to remain together. The Department saw it as a priority to try to keep the family group together, where possible, and ideally with a family member or significant other.[26] Mr Hine also signed a statutory declaration that day stating he had no criminal history or dealings with the Department that would impact on his ability to provide safe care to a child.[27]

29. On 25 March 2016 the deceased, her brother SD, half-brother JHD and half-sister AHD were taken into provisional care and placed in an emergency placement with Mr Hine. Mr Hine recalled he had been telephoned by the Department and told to come to Perth straightaway, but it actually took a couple of days before the removal of the children occurred. When the removal did occur, Mr Hine gave evidence he was surprised to find all four children at the police station, as he was only expecting to take the two older children, but he offered to take all of them when he realised they had all been removed. He was given temporary approval to take all four children and drove them home to Wongan Hills that night.[28]

30. The placement was initially recorded as unendorsed, until it was formally approved on 28 April 2016. Crisis Care staff and WA Police attended KD's home and KD was advised the children were being taken into care and placed with Mr Hine. Crisis Care indicated there could be phone contact between KD and the children at Mr Hine's discretion.[29]

31. On the same day, Crisis Care staff contacted the children's grandmother, LD, who advised she was travelling to Perth to support KD. She indicated she had regularly been staying with KD to help her with the children but would then return to her own home to attend to her animals and have some time-out from caring for the children. LD advised she could not manage the situation long-term and stated that she believed Mr Hine was capable of caring for all four children and had done so previously.[30]

32. Mr Hine gave evidence that he had contact with Departmental staff in the days following and they discussed his suitability as a carer and conducted criminal record checks and other necessary enquiries. The Department assisted him with obtaining furniture, as he didn't have enough beds for all of the children, and assisted financially with the purchase of food and clothing.[31]

[26] T 88, 90.
[27] Exhibit 1, Tab 12A, pp. 11 – 12.
[28] T 118 – 120.
[29] Exhibit 1, Tab 12A, p. 12.
[30] Exhibit 1, Tab 12A, p. 12.
[31] T 120 – 121.

PROGRESS AFTER CHILDREN FIRST TAKEN INTO CARE

33. On 31 March 2016 Department staff conducted a home visit at Mr Hine's home and completed an environmental check for the purpose of a relative carer assessment. The environmental check noted the home had child proof locks installed on kitchen and laundry cupboards but Mr Hine did not have, and required, a locked container for medication.

34. Mr Hine completed a health questionnaire stating he had excellent health and no prior medical problems, except for tonsillitis and two herniated discs in his back for which he was taking the following medications: "Tramidol [sic], Panadeine Forte and Meloxican."[32] Mr Hine gave evidence the Tramadol came in both sustained release and rapid release formats and he recalled the sustained release would make him a little nauseous and sleepy, but the effect of the rapid release was less dramatic. He also acknowledged he had built up a tolerance to the medication at that time, having taken it since 2015 when he hurt his back.[33]

35. Mr Hine also advised that due to a leaking air-conditioner in the girls' bedroom, AHD was sleeping in the lounge room and the deceased was sleeping in her own bed in his bedroom.[34]

36. Department staff approached KD on 13 April 2016 to discuss contact with her children and the steps she would need to take to have the children returned to her care. KD stated she did not want supervised contact with her children and had no interest working with the Department as she felt the 'system' had let her down. As a result, contact was cancelled.[35]

37. There continued to be domestic violence issues involving KD and BW and she was given assistance by the Department to file a new VRO, although there were also reports she had continued contact with BW and was not always reporting breaches.[36]

38. On 26 April 2016 a Family Court Consultant session was held with KD, Mr Hine and Department staff in attendance. The Family Consultant's report from that meeting noted that KD and Mr Hine made a number of allegations against each other in relation to their drug use and history. KD reported that Mr Hine had depression, for which he was medicated, and claimed he would go 'doctor shopping' for medications. She also alleged he had previously used all types of illicit substances, although she was not aware of him using any for the preceding two years. Mr Hine admitted previous use of cannabis, which he said he ceased using in 2014. Mr Hine alleged KD would smoke methylamphetamine twice a week, which she does not appear to have denied.[37]

39. As noted above, the placement of all four children with Mr Hine was formally approved by the Department on 28 April 2016. The record of carer assessment noted that Mr Hine had reported he attended counselling in the past for PTSD and depression. He said he currently stored his medications in a box in an above counter cupboard in the kitchen but intended to buy a lock for the box to ensure the medication was out of reach. He also indicated he did not believe in physical punishment of children.[38]

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[32] Exhibit 1, Tab 12A, p. 13.
[33] T 123 - 124.
[34] Exhibit 1, Tab 12A, p. 13.
[35] Exhibit 1, Tab 12A, p. 14.
[36] Exhibit 1, Tab 11, pp. 12 – 13.
[37] Exhibit 1, Tab 12A, pp. 14 – 15.
[38] Exhibit 1, Tab 12A, p. 15.

40. AHD suffered a broken collarbone on 2 May 2016, which was said to have occurred when she was tackled during a game of 'British Bulldog'. Supervised contact was resumed between KD and the children two days later but AHD did not attend due to shoulder pain.[39]

41. On 5 May 2016 the deceased underwent an Initial Health Assessment, which noted her weight and height corresponded to the third and tenth percentiles respectively and she had no significant medical conditions. She presented as pale and with an Upper Respiratory Tract infection at the time of assessment. The deceased attended the GP twice in the following days for the respiratory infection and was prescribed antibiotics.[40]

42. There was a serious reported domestic violence incident on 17 May 2016 when KD informed police BW was at her address armed with a knife and had threatened to kill her and her unborn baby.[41] She declined crisis accommodation but a safety plan was put in place. On 23 May 2016 KD reported to Department staff that JHD, SD and the deceased wanted to come home to live with her. She also reported concerns about AHD's behaviour. This was followed by concerns from the school that AHD was not attending following a cyberbullying incident. There was a report that JHD was also involved in a bullying incident at school shortly after. At this time Mr Hine requested that the school refer him to a parenting course in the area.[42]

43. On 3 June 2016 KD was advised that Mr Hine had agreed she could call his mobile phone weekly to have telephone contact with the deceased and SD. She reportedly stated she was glad Mr Hine was caring for the children and that he was a good dad.[43]

44. On 8 June 2016 the Department held a Signs of Safety meeting, which KD attended. Department staff raised concerns she had been drinking heavily and abusing prescription medications. However, it was noted she had complied with urinalysis requests, which were clean of amphetamine type substances. She had also agreed to engage in drug and alcohol counselling and family and domestic violence counselling. KD reported she was still happy that Mr Hine was caring for the children, if she could not have them with herself.[44]

45. In June 2016 the deceased commenced attendance three days a week at a daycare centre. It was reported she was blending in well.[45]

46. The deceased's father, BW, had been taken back into custody in June 2016 and he advised he was not in a position to care for his children if released from custody. However, he did not believe the children should have been taken into care and stated his belief KD was a good mother, did not use drugs and noted there was no current risk of family and domestic violence as he was not at home.[46] Department staff conducted a home visit at KD's house one week later and found the yard and house to be clean and well kept. KD began to see a psychologist around this time.[47]

47. KD had supervised contact with the deceased, SD and JHD on 24 June 2016 and appeared to be engaged and attentive to the children.[48] However, in July 2016 KD failed to comply with seven

[39] Exhibit 1, Tab 12A, p. 15.
[40] Exhibit 1, Tab 12A, p. 15 – 16.
[41] Sadly, KD later lost the baby at approximately 10 weeks' gestation.
[42] Exhibit 1, Tab 12A, p. 17.
[43] Exhibit 1, Tab 12A, p. 17.
[44] Exhibit 1, Tab 12A, p. 17.
[45] Exhibit 1, Tab 12A, p. 18.
[46] Exhibit 1, Tab 12A, p. 18.
[47] Exhibit 1, Tab 12A, p. 18.
[48] Exhibit 1, Tab 12A, p. 19.

urinalysis requests and later she admitted to staff she had been spiralling out of control throughout July.[49]

48. On 5 July 2016 the Department approved an internal submission that Mr Hine's criminal history should not preclude his continuation as a relative carer as he had made considerable changes in his life and was able to demonstrate insight into his past behaviours and was able to express clear strategies to prevent further criminal behaviour.[50]

49. On 11 July 2016 the Department finalised Mr Hines' 'Significant Other' Carer Assessment. It was noted he had a back injury managed with physiotherapy and medication. The medication was said to be stored in a box in the kitchen cupboard and he still intended to buy a locked box.[51]

50. KD had been exhibiting erratic behaviour and disordered thinking throughout July 2016. At a Signs of Safety meeting on 29 July 2016 she reported concerns that the children were living with Mr Hine as he was the son of a paedophile and was lazy, although she also indicated he was a good father.[52]

51. In August 2016 there were issues with JHD and AHD's school attendance. Both children were spoken to and did not report any concerns with their placement with Mr Hine but there were issues about them being bullied at school.[53] Mr Hine gave evidence at the inquest that he regretted moving to Wongan Hills as he felt there was a criminal element in the town and significant problems with bullying, which caused him to become quite depressed.[54]

52. BW had been released from prison on 3 August 2016 and between 30 August 2016 and 3 October 2016 police attended five incidents involving BW and KD.[55] On 4 October 2016 the Department suspended face to face contact between KD and her children due to her non-engagement with the Department. She underwent urinalysis on 14 and 18 October 2016 and tested positive to illicit substances, including methylamphetamine.[56]

53. On 4 November 2016 KD informed the Department that she had commenced counselling with Next Step Drug and Alcohol Services. Supervised contact resumed a week later.[57]

BEGINNING OF CONCERNS RE MR HINE'S CARE

54. There continued to be issues with the older children attending school and the reasons for that were explored. On 1 December 2016 the children's grandmother LD informed the Department she was worried AHD might have depression, the children were not attending school and she felt Mr Hine was not coping very well with the children. She reported he was not getting up in the mornings to the younger children and was sleeping all day. Mr Hine had reported a week earlier that he had undergone an epidural to assist with an exacerbation of his back pain.[58]

55. The Department made enquiries with the children's school and found AHD's attendance was only 48%. Both AHD and JD were interviewed separately about LD's concerns a few days later and they both reported they were happy living with Mr Hine and said their absences from school

[49] Exhibit 1, Tab 12A, pp. 19 - 20.
[50] Exhibit 1, Tab 12A, p. 19.
[51] Exhibit 1, Tab 12A, p. 19.
[52] Exhibit 1, Tab 12A, p. 20.
[53] Exhibit 1, Tab 12A, p. 20 – 21.
[54] T 125.
[55] Exhibit 1, Tab 12A, p. 20.
[56] Exhibit 1, Tab 12A, p. 21.
[57] Exhibit 1, Tab 12A, p. 21.
[58] Exhibit 1, Tab 12A, p. 22.

were due to illness. AHD was referred to the Wheatbelt Mental Health Service to explore her issues further.[59]

56. In January 2017 KD re-engaged with the Department to progress reunification requirements and complied with urinalysis requests, which were positive for cannabis and sometimes opiates (codeine). BW returned to prison at the end of that month and on 2 February 2017 AHD returned to live with her mother. Mr Hine informed the Family Court he had made this arrangement with KD as he was concerned AHD was experiencing depression and anxiety and wasn't attending school due to bullying. JHD's behaviour apparently improved after AHD left Mr Hine's home.[60]

57. The deceased was sighted by her case manager on 20 January 2017, 3 March 2017 and 17 March 2017 for her Quarterly Case Reports and there were no concerns recorded for her while in Mr Hine's care. However, there remained concerns about the other children's low school attendance, particularly SD. The school informed the Department that Mr Hine appeared to be doing the best he could caring for three children by himself with little support or respite.[61]

58. SD's school attendance did not improve and it became apparent in late March 2017 that the deceased was also not attending her daycare. The daycare centre indicated she had been absent on 42 occasions since the start of the year (noting she was only enrolled to attend three days a week). When asked, Mr Hine reported that her absences were due to appointments in Perth and sickness in the home.[62]

59. On 28 March 2017 a Magistrate in the Perth Children's Court granted Protection Orders (Time Limited) for two years for the deceased and SD. KD neither consented to, nor opposed, the orders.[63]

60. There continued to be issues with poor school attendance with SD and JHD and absences from daycare by the deceased in April. Illness was again given as the cause by Mr Hine. Around this time additional supervised contact began between KD and the deceased and SD, facilitated by their grandmother.[64]

61. KD had a positive urinalysis for methylamphetamine on 26 April 2017, indicating she was still struggling with drug issues.

62. Around this time it became known that KD was pregnant with her fifth child, and the Department became involved in pre-birth planning with KD.[65]

63. An email was sent by the school's Deputy Principal to the Department on 28 April 2017 reiterating concerns about SD's and JHD's non-attendance at school.

64. On 29 April 2017 there was a change in the Department's case manager. The outgoing case manager, Nadia Thomas, sent an email to the incoming case manager noting, "I have had many conversations with [Mr Hine] regarding [SD's] extreme low attendance. [Mr Hine] is not meeting the carer competencies."[66] The new case manager gave evidence she did not have access to emails at this time, so she would not have received this email.[67]

[59] Exhibit 1, Tab 12A, p. 22.
[60] Exhibit 1, Tab 12A, p. 23.
[61] Exhibit 1, Tab 12A, p. 24.
[62] Exhibit 1, Tab 12A, p. 24.
[63] Exhibit 1, Tab 12A, p. 25.
[64] Exhibit 1, Tab 12A, p. 25.
[65] Exhibit 2, Tab 1, SC6.
[66] Exhibit 1, Tab 12A, p. 26; Exhibit 2, Tab 2.
[67] T 33.

65. An email was sent by Ms Thomas to the relevant Team Leader on 30 April 2017 setting out a list of urgent and outstanding matters in relation to the deceased and the other children, which she asked to be provided to Ms Crawford. There is no mention of the need to follow up a locked box for Mr Hine's medication in this email and Ms Crawford has stated that she does not recall being told that Mr Hine needed to obtain a locked box for his medications.[68] Ms Crawford gave evidence that she was not aware until the inquest that Mr Hine was ever felt not to be meeting the competencies and it was also not something that was highlighted to her at any stage.[69]

66. The new case manager, Ms Crawford, had only commenced work with the Department as a child protection worker, based at the Armadale District, on 18 April 2017. Ms Crawford had a background in policing and social welfare in the United Kingdom and tertiary qualifications in psychology and counselling, but had not worked in child protection before. Ms Crawford was initially engaged on a short term three month contract and did not receive any training from the Department before she commenced work. Instead, she received 'on the job training' and then participated in a number of training courses at various stages.[70]

67. Ms Crawford indicates that she could not be officially allocated as a case manager when she first started, as she had not completed the necessary training, but was tasked to do various tasks for the deceased and her family by her supervisor. She was eventually officially allocated as the family's official case manager on 20 June 2017, after she had completed her compulsory training. Ms Crawford gave evidence that there was little substantive difference in the role she played before and after she was allocated as the case manager, and in her view it was more of a change in terminology than anything practical. Certainly from the family's perspective, they appeared to view her as their official case manager from the time she commenced.[71]

68. Ms Crawford understood that the Armadale District office, rather than the Northam office (which was much closer to where they were living with Mr Hine in Wongan Hills) was managing the family's case because the children's mother, KD, was in Armadale and the aim was to reunite the children with their mother. KD was also pregnant with another child, so there was pre-birth planning to be conducted with her. It was a six hour round trip from Ms Crawford's workplace in Armadale to Wongan Hills, but KD lived very close by the Armadale office.[72]

69. Ms Crawford understood her primary purpose when she became involved with the deceased's family was reunification and also pre-birth planning in relation to KD's pregnancy. She was also aware that SD was not attending school, there had been an alleged incident involving KD and her oldest child, AHD, that needed to be followed up, and KD's ongoing urinalysis needed to be monitored. The children's care plan was also overdue.[73]

70. On 5 May 2017 LD spoke to Ms Crawford and advised she was en route to visit Mr Hine as he had contacted her in tears stating that he believed he had broken his wrist. This was the first direct contact Ms Crawford had with the family.[74] On 8 May 2017 Mr Hine confirmed with the Department he had broken his wrist in a fall and might require surgery. He advised that the children's grandmother, LD, had come to stay with him and assist in caring for the children.[75]

71. LD indicated in her statement that she stayed with Mr Hine and the children for about five weeks. When she arrived at the house she described it as messy but while she was living there

[68] Exhibit 2, Tab 1 [24] and Tab 3.
[69] T 28.
[70] T 22, 25 - 27; Exhibit 2, Tab 1.
[71] T 26 - 27; Exhibit 2, Tab 1.
[72] T 23 – 25.
[73] T 31.
[74] T 33; Exhibit 2, Tab 1, SC1.
[75] Exhibit 1, Tab 12A, p. 26; Exhibit 2, Tab 1, SC2.

she kept the house clean and got the children into a routine so that they were attending school on a regular basis. However, when she left she believes the home situation "turned back to the way it was before."[76]

72. On 22 May 2017 Sarah Crawford had a phone conversation with Mr Hine to discuss arranging a visit with him, so she could meet him and his family and also to have a meeting with the school to discuss SD's progress and educational needs. Ms Crawford made a note at the conclusion of the conversation that Mr Hine was cooperative, appeared focussed on the children's best interests and was a 'nice chap' and seemed easy to work with.[77]

73. On 25 May 2017 Ms Crawford spoke with LD about various issues. LD became tearful during the conversation. LD said she felt reunification should be proceeding at a faster rate and she felt Mr Hine was 'getting low' and LD needed to organise some operations but she was waiting to organise them once reunification had progressed. It is apparent from this case note, and others, that LD was bearing a lot of the load in supporting both KD and Mr Hine with the children at that time. Ms Crawford recalled that she understood that Mr Hine was feeling low because of his wrist injury, which was a natural response, and she did not interpret the discussion as requiring any particular action or assistance in relation to Mr Hine.[78] If Mr Hine had required support or respite care, Ms Crawford indicated that would have been a matter for the placement officer, rather than herself.[79]

74. Arrangements were made on 1 June 2017 for KD to commence counselling sessions to address her drug use and improve her parenting skills.[80]

75. On 6 June 2017 the planned home visit took place between Department staff and Mr Hine regarding the deceased and SD. Ms Crawford was one of the people who attended. Mr Hine stated SD was resistant to attending school but he was working with the school to improve his attendance. His house was observed to be clean and tidy inside and out and his kitchen cupboards were full of food but the Department's staff did not venture beyond the kitchen to look at the state of the bedrooms or rest of the house. Ms Crawford gave evidence that if she had known about the issue regarding the medication lock box, she would have looked for it during this visit, but she was not aware it was an issue at that time. She had also learnt from this case to inspect the rest of a house, when visiting, but she was still very new to the role at that time and it was not suggested by her team leader or the education officer who attended with her.[81]

76. Mr Hine indicated he was still being supported by LD and had started a new relationship and was the happiest he had ever been. The Care Plan also notes positive feedback regarding the deceased's engagement at her daycare centre and Ms Crawford gave evidence she was unaware that there were any issues with LD's attendance at that time.[82]

77. A meeting that same day at the school identified ongoing issues with SD's school attendance, his decreasing academic performance as a result and his disrespectful behaviour to teachers and other students. They discussed options for getting SD to attend school more regularly and ways to manage his behaviour.[83]

[76] Exhibit 1, Tab 15 [37].
[77] Exhibit 2, Tab 1, SC9.
[78] T 34; Exhibit 2, Tab 1, SC11.
[7979] T 34 – 35.
[80] Exhibit 2, Tab 1, SC15.
[81] T 31, 35.
[82] T 32; Exhibit 1, Tab 12A, p. 26; Exhibit 2, Tab 1, SC17.
[83] Exhibit 2, Tab 1, SC19.

78. The following day Department staff conducted a care planning meeting with KD and LD to discuss arrangements for SD and the deceased. It was noted that KD agreed with the Department's decision to keep the children with Mr Hine while reunification was progressed (which was later explained on the basis that KD was concerned if the children moved to a different carer, it would slow the reunification process). KD stated she maintained a positive relationship with Mr Hine and was hoping he would relocate to Perth soon to facilitate the reunification process and provide her with additional family support. Ms Crawford commented in her evidence that KD and Mr Hine appeared to have a "conflictual relationship"[84] as on the one hand KD described him as a support, but on the other hand he was quite negative about KD and did not feel that she was ready for reunification with the children.

79. They were keen for unsupervised visits with KD to begin. The main concern of the Department's staff around this time remained KD's believed continued drug use and concerns that if she did not seek treatment for her drug use she would be unable to meet the children's basic needs if she resumed their care.[85]

80. Ms Crawford met the children, including the deceased, during a supervised visit with KD and LD on 9 June 2017 and everyone appeared to be enjoying their time together. LD spoke to Ms Crawford about her hopes for Mr Hine to come down to Perth to support KD.[86]

81. From 12 to 16 June 2017 Ms Crawford completed the Department's Orientation Program training and was now able to be allocated as a case manager, which occurred on 20 June 2017, when she was allocated as the deceased's family case manager. This formalised the role she had, in effect, already been performing.[87]

82. Unfortunately, things began to deteriorate after this time. On 21 June 2017 LD reported to Ms Crawford that she was exhausted from supporting Mr Hine with manual work around the house and on 14 and 27 June 2017 KD's urinalysis samples tested positive for methylamphetamine, cannabis and codeine.[88]

83. Notes were made of the efforts LD was making to provide domestic support to KD and Mr Hine and all the driving she was doing to facilitate contact visits, for which she was reimbursed her fuel costs but nothing more.[89] Ms Crawford noted that everything was culminating around this time, with KD getting close to giving birth and there was a fast-approaching reunification, and LD was having to travel long distances. Ms Crawford confirmed that no specific support was offered to LD at this time or to consider what more could be done to relieve her responsibilies in relation to Mr Hine. In hindsight, Ms Crawford agrees that a thorough assessment of Mr Hine's needs was warranted at that time, including if he required respite, but she was still learning her role and at the time it appeared to her that LD was really just venting her frustrations rather than actively seeking assistance.[90]

84. Sometime around then, LD was cleaning Mr Hine's house and she found a pair of hotel slippers. She had noted the house was constantly messy and she believed he was using drugs due to his behaviour. LD said she confronted Mr Hine about "his behaviour, the state of the house and the kids not going to school." Mr Hine told her it was because he was on a lot of medication.[91] He agreed in his evidence at the inquest that the house had become messy around this time and they

[84] T 36.
[85] Exhibit 1, Tab 12A, pp. 26 – 27; Exhibit 2, Tab 1, SC21 – SC22.
[86] T 36; Exhibit 2, Tab 1, [58] and SC25.
[87] Exhibit 2, Tab 1 [60].
[88] Exhibit 1, Tab 12A; Exhibit 2, Tab 1 [64].
[89] Exhibit 1, Tab 1, SC36.
[90] T 38.
[91] Exhibit 1, Tab 15.

were staying away at hotels, but the more time they spent away the more it got messy when they returned and he was struggling and overwhelmed by this stage.[92]

85. On 11 July 2017 Ms Crawford spoke to KD about her positive urine samples. She did not wish to discuss her own drug use and stated she did not believe her drug use was an issue requiring management. KD instead raised concerns about Mr Hine's care of the children and the lack of attention SD and the deceased were receiving from their case manager and the Department generally. KD appeared frustrated that the focus was on her and not Mr Hine. KD stated she believed it was 'sickening' how little focus there had been on Mr Hine's care of the children and alleged he had physically hurt the children. KD refused to elaborate further on these allegations and stated the Department should question the older children if they wanted more information. KD also suggested Mr Hine should be drug tested.[93]

86. KD also raised concerns about BW's behaviour in front of the children, which resulted in a decision he should have no contact with them.[94]

87. Ms Crawford raised KD's allegations about Mr Hine with her Team Leader and then confirmed them in an email to her Team Leader on 13 July 2017, before she went to complete two weeks' compulsory training.[95] Ms Crawford advised her Team Leader in the email that she had not yet followed up with Mr Hine to discuss the allegations made by KD.[96] Ms Crawford explained that they were specifically instructed to hand over all of their case management when training so that they could focus solely on their training. Therefore, Ms Crawford had an expectation that someone else would take charge of the matter and do something about the complaints while she was absent.[97] However, it does not appear that any action was taken in her absence.

88. The deceased's Quarterly Care Report, prepared on 18 July 2017, noted that the Department was worried that KD had not sufficiently engaged with the Department or support services to address issues of drug use and violence in the home and they were concerned the deceased might be placed in a situation where she was at risk of physical and emotional harm if she returned to the care of her mother. It was wrongly suggested in that document that there had been no concerns reported regarding the deceased's placement arrangement with Mr Hine from the community, the deceased's siblings or family.[98] At that time, the deceased had last been sighted at the Department's office on 6 January 2017, although I note that she was also seen by Department staff during contact visits, including Ms Crawford on 9 June 2017.

89. On 21 July 2017 the school advised that SD had not been seen at school at all that term. By the end of the month he had only attended one day and on 28 July 2017 the school's Deputy Principal reported grave concerns regarding SD's welfare and school attendance and asked for Ms Crawford's assistance. It was indicated that SD's "engagement and learning is basically non-existent"[99] and he was felt to be at high risk, which I presume meant from an academic perspective. Mr Hine did not attend a scheduled meeting with the school about this issue.[100]

[92] T 148.
[93] Exhibit 1, Tab 12A, p. 27; Exhibit 2, Tab 1, SC47.
[94] Exhibit 1, Tab 12A, p. 27; Exhibit 2, Tab 1, SC28.
[95] T 39.
[96] Exhibit 2, Tab 1, SC 57.
[97] T 26, 39.
[98] Exhibit 2, Tab 1, SC58, Quarterly Care Report, p. 1.
[99] Exhibit 2, Tab 1, SC58, Email dated 28 July 2017 to Sarah Crawford from Pam Boase.
[100] Exhibit 1, Tab 12A, p. 28.

90. At the same time, KD was preparing for the birth of her child. She still expressed a desire around 20 July 2017 for Mr Hine to be in her circle of support for this child.[101] KD commenced having unsupervised contact with SD and the deceased around this time.[102]

91. On 1 August 2017 Ms Crawford returned to her duties and spoke to Mr Hine on the telephone to discuss SD's lack of school attendance and to plan a visit in order to investigate the concerns that had been raised. Mr Hine stated he had started driving again but was still experiencing pain from his wrist injury. He was still undecided about relocating to Perth as he was not yet ready to manage the physical burden of relocating. He advised that SD had not been attending school as he had been sick and/or Mr Hine had been in pain and unable to take SD to school. Other ways to get SD to school were discussed and Mr Hine was encouraged to engage with SD's teacher.[103] No concerns were expressed about the deceased, who was thought to be attending day care regularly at that time, although I note an account from her daycare issued on 22 August 2017 indicates she was actually absent that day and the following day. Ms Crawford advised it would be unusual for the daycare operators to provide that information to the Department, and usually it would only be identified when she would follow up quarterly as part of the care planning.[104]

92. Mr Hine was also advised of KD's allegations he was taking illicit drugs, although he was not told the source of the allegations.[105] He denied the allegation but agreed to complete urinalysis, which he indicated he believed would come back negative as he said he did not take illicit drugs. Ms Crawford told Mr Hine she would organise a visit and would like to see the children during the visit after she completed her training on 14 August 2017.[106] Ms Crawford found Mr Hine to be cooperative and willing to engage and work with the Department.[107] No date was set for the planned visit during the conversation as Ms Crawford still needed to complete her next training course from 7 to 11 August, but it was discussed that it would be during the week commencing 14 August 2017 when she returned to work.[108]

93. LD has provided information to the court that around this time she was concerned that Mr Hine had begun using drugs as he had received an insurance payout, which gave him funds to buy drugs if he wished. She had been staying with Mr Hine regularly to assist him with the care of the children after he broke his wrist, and she believed strongly that the situation was going downhill. She states that she was desperate for the Department's staff to go to Mr Hine's house for a visit as she believed it would have been apparent that the house was in disarray and he was leaving medicine lying around. LD recalls that she spoke to the children's new case worker, Ms Crawford, who she had been advised was new to the Department, and was told the Department's staff were very busy and she couldn't come to the house for another few weeks. LD says she was upset and cried at the end of the phone conversation.

94. On 5 August 2017 the children had a successful unsupervised visit with their mother, who indicated it was difficult to be parted from the children when their allotted time had finished.[109]

95. Between 4 August and 7 August 2017 there was quite a lot of work done in relation to emergency dental work required by SD. Mr Hine was responsive and cooperative in making these arrangements. Ms Crawford gave evidence there was nothing to cause her to be concerned that Mr Hine was being neglectful or unresponsive to the children's needs based upon her dealings

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[101] T 39 – 40.
[102] Exhibit 1, Tab 12A, p. 28.
[103] Exhibit 1, Tab 12A, p. 28; Exhibit 2, Tab 1, SC61.
[104] T 44; Exhibit 2, Tab 1, SC80.
[105] T 40.
[106] Exhibit 1, Tab 12A, p. 28; Exhibit 2, Tab 1, SC61.
[107] T 40, 46 - 47.
[108] T 41.
[109] Exhibit 2, Tab 1, SC70.

with him around this time. There was also nothing in her dealings with him that suggested that there was an issue with him abusing illicit drugs.[110]

96. On 9 August 2017, while Ms Crawford was still training, SD's school contacted the Department relating to further concerns about his continued non-attendance.[111]

97. On 10 August 2017 KD had a positive urinalysis for methylamphetamine, codeine and cannabis. A week earlier a home visit had been conducted at KD's home to assess it for unsupervised contact with the children, and KD had indicated she did not wish to work with Wanslea.[112] I note the Practical Checklist completed at this time covers harmful products, and specifically medication, being kept in a safe location inaccessible by a child, which for KD's home was ticked 'yes'.[113]

98. At 10.27 am on 14 August 2017, LD spoke to Ms Crawford and advised she had been staying with KD, who had started to have contractions. LD expressed some more concerns about Mr Hine's house, which was becoming messy, and suggested it would be a good idea for the Department to check how Mr Hine was managing and to make sure all the rooms in the house were checked during the visit.[114] Ms Crawford did not perceive the request to be urgent, as LD already knew Ms Crawford was planning a visit, and understood LD was simply encouraging her to undertake a comprehensive inspection when she went there. LD specifically said to Ms Crawford, "Make sure you go through the whole house."[115] After she received this call, Ms Crawford attended supervision with her Team Leader, Ms Rowles, in relation to the upcoming visit with Mr Hine, which was already planned.[116] No urinalysis testing had been arranged for Mr Hine at this stage, despite him agreeing to undertake it.[117]

99. After the meeting with her Team Leader, Ms Crawford made a plan to liaise with the deceased's daycare regarding her progress and arrange a home visit to Mr Hine's house to organise urinalysis, conduct a full inspection of his home and discuss his care of the children, SD's school attendance and the allegations made by KD further.[118] Regrettably, the deceased died that afternoon, before the plan could be carried out.

100. Ms Crawford recalled in her evidence that at the time she was discussing arrangements with her Team Leader on 14 August 2017, there was no sense of urgency to investigate the concerns, although arrangements were being made.[119]

EVENTS LEADING TO HER DEATH

101. As noted above, Mr Hine had broken his wrist in May 2017 and had a pre-existing back injury that caused him chronic pain. He was prescribed opioid pain relief medications in the form of tramadol 50 mg capsules and tramadol 200 mg sustained release (SR) tablets to assist with pain management. Mr Hine's last prescription for the medications was dispensed on 8 August 2017 and he was given a packet of 20 x 200 mg SR tablets to last 20 days (1 tablet per day) and a packet of 20 x 50 mg capsules to last 2.5 to 5 days. According to the prescription, by 14 August

[110] T 41, 47.
[111] T 41.
[112] Exhibit 1, Tab 12A, p. 28.
[113] Exhibit 2, Tab 1, SC63.
[114] Exhibit 1, Tab 12A, p. 28; Exhibit 2, Tab 1, SC71.
[115] T 42.
[116] Exhibit 2, Tab 1 [107] – [108].
[117] T 43.
[118] T 43; Exhibit 1, Tab 12A, p. 28.
[119119] T 43 – 44.

2017 Mr Hine should have used all of the capsules and only six of the tablets, with 14 tablets remaining.[120]

102. LD recalled that when she was cleaning Mr Hine's house before the deceased's death she "would find his medication everywhere."[121] LD stated Mr Hine would leave his medication all over the house and she would put it away. She had never seen any of the children trying to take the tablets from their blister packs before she could move it.[122]

103. On the Saturday of the weekend before her death, the deceased and her two brothers were collected by their grandmother and taken to KD's for a home visit. LD recalls that she was meant to collect them from Mr Hine at 11.00 am but he was running late. She drove to the Goomalling Service Station to meet him. He did not arrive there until 12.30 pm. While they were completing the handover of the children at the Goomalling Service Station, Mr Hine asked LD if she could keep the children for a sleepover. She declined as she was concerned they would get into trouble if the Department found out and they might stop allowing the children to visit KD.[123]

104. Mr Hine gave evidence at the inquest that he had asked LD to take the children as he had "been struggling and … just needed a bit of time for myself."[124] He recalled he had already, by this time, discussed with Department staff the fact that he was suffering with depression due to his broken arm and the workload with the children, the fact the children were being bullied and the bad element his son was hanging around with, leading him into trouble with police. He recalled he wasn't offered any extra support from the Department, rather it fell to him and LD to try to manage and deal with it as best they could.[125]

105. It was approximately a two hour drive from Goomalling back to KD's home. LD recalls the children had a good visit and played and ate well. The deceased appeared happy and excited. LD recalls the deceased had a sniffle at the time, but she wasn't coughing and did not appear sick. The visit finished later than usual, because it had started late, and the children had fallen asleep in LD's car on the long drive back before she transferred them to Mr Hine's care late in the evening.[126]

106. Mr Hine advised police and Department staff that he had picked up the deceased and SD late on the Saturday night after their contact visit and they had arrived home in the early hours of Sunday morning. The deceased had been fine on the Sunday morning but both SD and the deceased appeared to be coming down with a cold, both with snotty noses and appearing tired. Mr Hine recalled it was the middle of winter and freezing at the time, so it was perhaps not surprising they had become ill.[127]

107. On the Sunday morning the deceased had tea and toast and SD and the deceased slept in the lounge on and off throughout the day in front of the heater. The deceased ate her dinner and then lay on a mattress in the lounge room. At about 7.00 pm the deceased vomited a small amount and she looked unwell, like she had the 'flu'. She went back to sleep, but at about 8.30 pm the deceased vomited again, which Mr Hine described as a small amount of frothy yellow liquid. The deceased then got up and he noticed she had a little stagger. She wanted to go to the toilet, so Mr Hine took her to the toilet. The deceased then went to bed in Mr Hine's room while he slept in the lounge room.[128]

[120] Exhibit 1, Tab 9.
[121] Exhibit 1, Tab 15 [94].
[122] Exhibit 1, Tab 15 [95].
[123] Exhibit 1, Tab 15.
[124] T 130.
[125] T 130 - 131.
[126] Exhibit 1, Tab 15 and Tab 18C.
[127] T 132; Exhibit 1, Tab 16A – B; Exhibit 2, Tab 1, SC76 & SC81.
[128] Exhibit 1, Tab 16A – B; Exhibit 2, Tab 1, SC76 & SC81.

108. Mr Hine said he woke at about 8.00 am and got JD ready for school, then checked on SD and the deceased. They both appeared to be still sick so he decided to keep them home for the day. He left them in bed and said he looked in on them a couple of times throughout the morning.[129]

109. When spoken to by Department staff on 15 September 2017, Mr Hine was asked if it was possible the deceased had died the previous night, but he maintained he did at least see her alive in the morning when he first checked on her at about 8.00 am and she had moved position in the bed from that time to when he found her unresponsive in the afternoon.[130] I will return later to his evidence at the inquest on this important issue.

110. At around 11.30 am Mr Hine said he had a lengthy argument with a Shire ranger about his dog at the front of his house. He did not check on the children during this period.[131] The ranger recalled she spoke to Mr Hine around 12.15 pm and she believes she left his house at 12.39 pm.[132] Mr Hine believes it was a much longer conversation, in the order of an hour and a half.[133]

111. At around 2.00 pm, when Mr Hine returned to the house, he saw SD was up watching television and he asked SD if the deceased was up. SD indicated she was not. Mr Hine went in to check on the deceased and noticed she had changed position from before. He touched her and she felt wet and she was floppy when he picked her up. He realised something was very wrong and was in a state of panic. He couldn't remember how to perform CPR properly, so he took her to his car and drove her immediately to the hospital, which was only about 500 metres from his home.[134]

112. Mr Hine confirmed that on the Monday morning he had not given the deceased any food or fluids and had not taken her to the toilet. He maintained she was sleeping the whole time and he did not wake her up to do any of these things. He was asked if he thought the fact she had slept for 12 hours unusual, and Mr Hine said he had put it down to the cold.[135]

113. Mr Hine denied giving the deceased any Panadol or cold/flu medication when asked by the Department's staff on 15 September 2017. When speaking to Ms Crawford on 15 August 2017 Mr Hine made a reference to the possibility that the deceased could have taken one of his tablets, but he had never done anything deliberate to harm her or any of the children.[136]

CAUSE OF DEATH

114. Dr Yoshi Inoue at the Wongan Hills Hospital certified the deceased as life extinct at 2.54 pm on 14 August 2017, shortly after she was brought into the hospital by Mr Hine. It is clear she showed absolutely no signs of life at the time she was brought in to the Emergency Department. She was cold to the touch, cyanotic and her pupils were fixed and dilated.[137]

115. On 18 August 2017 Forensic Pathologist Dr Judith McCreath made a post mortem examination of the deceased. She noted that the deceased had a history of being lethargic and vomiting for around 24 hours before being found deceased in her bed. The examination found a swollen brain,

[129] Exhibit 2, Tab 1, SC76 & SC81.
[130] Exhibit 2, Tab 1, SC81.
[131] Exhibit 2, Tab 1, SC81
[132] Exhibit 1, Tab 17.
[133] T 142.
[134] T 143; Exhibit 2, Tab 1, SC73, SC81.
[135] Exhibit 2, Tab 1, SC81.
[136] Exhibit 2, Tab 1, SC76.
[137] Exhibit 1, Tab 9, p. 3 and Tab 18.

haemorrhagic lungs, aspirated gastric contents in the upper airways and four undissolved tablets within the stomach. The tablets were examined and found to be tramadol tablets.[138]

116. Microscopic examination of the lung tissue showed pneumonia and analysis of the liver showed the presence of tramadol. Toxicological analysis of the blood showed the presence of tramadol and paracetamol and tramadol and its metabolite were also present in the urine.[139]

117. To assist her in forming her opinion as to the cause of death, Dr McCreath was provided with an opinion by Professor David Joyce, a clinical pharmacologist, on the toxicological findings. Professor Joyce often provides expert evidence to this Court on matters where the death appears to have been drug related. Professor Joyce considered the evidence obtained in the investigation into the deceased's death and provided a report in relation to how tramadol played a role in her death. Professor Joyce's opinion is discussed below, in the context of the manner of death.

118. After considering the results of all investigations and the information provided by Professor Joyce, Dr McCreath formed the opinion the cause of death was tramadol toxicity.[140]

119. Dr McCreath was unavailable to give evidence at the time of the inquest, so Dr Jodi White, also a Forensic Pathologist, attended to give evidence in relation to the post mortem examination results. Dr White had reviewed the relevant materials and agreed with the conclusions of Dr McCreath.

120. Dr White noted that the deceased appeared to be generally healthy, with no sign of significant injuries, so the significant findings were those that appeared to relate to the tramadol toxicity.[141] The finding of a pneumonia in the lungs was consistent with the deceased being heavily sedated from tramadol and not breathing well, leading her to develop pneumonia over a number of hours prior to her death. The cerebral swelling could also indicate that there was a period prior to her death where her brain was low on oxygen, causing hypoxic brain injury, which can also develop over a number hours if a person is heavily sedated and is starting to develop pneumonia.[142]

121. Further neuropathological examination of the deceased's brain by neuropathologist Dr Vicki Fabian found the presence of axonal spheroids indicating a survival time of some hours, usually occurring within a time range of two to five hours. Further, the absence of certain other findings meant death occurred within less than two days.[143]

122. I accept and adopt Dr McCreath and Dr White's opinion as to the cause of death. The evidence supports the conclusion the deceased ingested a toxic quantity of tramadol and became heavily sedated, which meant she was unable to protect her airways and breathe properly and over a number of hours, in the range of at least two and no more than five, she developed pneumonia and eventually went into cardiorespiratory arrest.[144]

123. The post mortem evidence does not give an indication as to whether the deceased took the tablets herself or was given them by another person.

[138] Exhibit 1, Tabs 3 – 5.
[139] Exhibit 1, Tabs 3 - 5.
[140] Exhibit 1, Tabs 3 – 5.
[141] T 78 – 79.
[142] T 73 - 75.
[143] Exhibit 5.
[144] T 75.

MANNER OF DEATH

Commencement of Homicide Investigation

124. Although the WA Police were immediately notified of the deceased's death and it was apparent it was going to be a coronial investigation as an unexpected and unexplained death, prior to the post mortem examination findings there did not appear to be any obvious suspicious circumstances in relation to the death. However, following the discovery that the deceased died as a result of tramadol toxicity, the Homicide Squad took charge of the police investigation as per standard operating procedures relating to all suspicious deaths.[145]

125. The investigating officer was Detective Sergeant Matt Lewis. The Homicide Squad investigation explored the circumstances surrounding the death and the cause of death and considered whether it could be established that there was criminal culpability of any person in relation to the death.[146]

126. The primary incident scene was identified as Mr Hine's home in Wongan Hills. The home was searched and within the bedroom where the deceased had been sleeping prior to her death (Mr Hine's bedroom) police seized:
- 1 blister pack of 200 mg sustained release (SR) Tramedo (tramadol) tablets containing 1 tablet;
- 1 blister pack of 50 mg Tramedo (tramadol) capsules containing 1 capsule; and
- 1 bottle of children's pain relief syrup.

127. They were found in the room on top of a set of tallboy drawers, where a television was also situated.[147]

128. Mr Hine told police he only took his prescribed doses of his medications which, if correct, should have resulted in 14 of the 200 mg tablets remaining and none of the 50 mg capsules.[148]

129. In a kitchen cabinet was also found a box of Lemsip Max Cold and Flu drink, which was mentioned in some evidence. Mr Hine denied giving any to the deceased.

Interviews with Mr Hine

130. Department staff conducted a number of interviews with Mr Hine, and in addition Mr Hine provided an initial witness statement to police and then was formally interviewed by police on video after being cautioned. Mr Hine cooperated with all attempts to interview him. He also attended the inquest and gave evidence and answered all questions without seeking to exercise his right against self-incrimination or seeking a certificate under s 47 of the Act before answering.

131. In the interview with police on 27 December 2017 Mr Hine maintained that the deceased did not like taking medication and denied giving her his medication or any other medication immediately prior to her death.[149] Mr Hine told police he understood the medication he was prescribed for his back "would be very dangerous for a child"[150] and could result in an overdose

[145] Exhibit 1, Tab 9, p. 3.
[146] Exhibit 1, Tab 9, p. 3.
[147] Exhibit 1, Tab 19 – Photos 3, 4, 15 – 18.
[148] Exhibit 1, Tab 16C, p. 69.
[149] Exhibit 1, Tab 16C, p. 55 – 56.
[150] Exhibit 1, Tab 16C, p.102.

and he was adamant he would never have given her any to take.[151] He was unable to offer any explanation to police as to how the deceased came to ingest the tramadol, other than she came across it because he left it lying around.[152] He did, however, admit to giving her a little sip of Lemsip on one or two occasions.[153]

132. Mr Hine was asked whether the deceased or any of the other children had ever taken his tablets before, and he related a story of the children, including the deceased, eating Vitamin C tablets but that was all.[154]

133. Mr Hine acknowledged that the Department required him to have a locked box for storing medication and he "got a bit lazy with that."[155] He admitted that LD had reminded him in the past that he needed to be more careful with his medication and put it away out of reach.[156] He told police he would usually store it in the kitchen cupboards above the stove but acknowledged that detectives found some on top of the tallboy in his bedroom after the deceased's death.[157] Mr Hine admitted to police he was a heavy pot (cannabis) smoker for a long time and he was sporadically using amphetamines, including in the week before her death.[158]

134. At the end of the electronically recorded interview the police concluded there was insufficient evidence to proceed with any charge and Mr Hine was unconditionally released from custody.[159]

Interviews with the children JHD and SD

135. JHD was interviewed by police on 24 October 2017 and his recollection matched the description given by Mr Hine of the deceased appearing to have the flu and vomiting before going to bed. JHD said he gave her a hug before she went to sleep. She was still asleep when JHD went to school in the morning, so he did not see her again before her death. He was aware his father took sleeping tablets but did not see him give any to the deceased.[160]

136. JHD was interviewed again on 18 December 2017 and stated he was aware the deceased had been sick, with a runny nose and a cough, and he recalled that his father gave the deceased a glass of water and half a pill but she wouldn't drink it. He thought it was a Nurofen tablet. However, JHD then said he was rushing to go to school, so didn't see if she drank it, which is inconsistent with his earlier account of not seeing the deceased in the morning before going to school.[161]

137. SD was interviewed by police on 25 October 2017 and he recalled the deceased being sick and vomiting twice in the lounge room before they both went to bed. When he woke up Mr Hine was already awake and SD recalled Mr Hine checking on the deceased and finding she had died and taking her to the hospital. SD recalled Mr Hine had given the deceased a lemon drink twice, which would be consistent with him giving her Lemsip, and he mentioned it having a tablet in it although he then said he didn't see the tablet but believed Mr Hine told him there was a tablet in it.[162]

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[151] Exhibit 1, Tab 16C, p.117, 158 - 159.
[152] Exhibit 1, Tab 16C, pp.165 - 166.
[153] Exhibit 1, Tab 16C, pp. 153 - 155.
[154] Exhibit 1, Tab 16C, p. 169.
[155] Exhibit 1, Tab 16C, p.110.
[156] Exhibit 1, Tab 16C, pp. 164 – 167.
[157] Exhibit 1, Tab 16C, pp. 110 – 112.
[158] Exhibit 1, Tab 16C, p.113 - 114.
[159] T 15.
[160] Exhibit 1, Tab 23B.
[161] Exhibit 1, Tab 25D.
[162] Exhibit 1, Tab 24D.

138. On 31 January 2019 the deceased's mother emailed the Coroner's Office and advised that she believed her younger son, SD, had recently disclosed information that was relevant to the coronial investigation into the deceased's death. As a result of this email, Detective Senior Constable Ross Peters from the Homicide Squad facilitated another Specialists Child Interview for SD, which was conducted on 2 April 2019 by two female police officers. No further information was obtained from SD that was considered would progress the coronial investigation, noting the information was felt to be inconsistent and unreliable. Allowance was made for his young age in considering his ability to provide a coherent account. The deceased's mother was advised of this outcome.[163]

139. During the inquest it was suggested that the children might have additional evidence to give. However, I note that they were interviewed very close in time to the death and there were concerns about the reliability of their evidence even then.

Opinion of Professor Joyce

140. As noted above, Professor Joyce provided a written report, and gave oral evidence, in relation to the role that drugs played in the death of the deceased. The toxicological analysis of the deceased's blood samples found paracetamol and tramadol but no other common drugs.[164]

141. Professor Joyce was aware of the suggestion that the deceased may have been given 'Lemsip' on the evening prior to her death, and noted there are around a dozen formulations that include the trade name 'Lemsip', and some have paracetamol in them, but none contain any tramadol. Lemsip formulations are conventionally used for coughs and colds.[165] Professor Joyce noted that the paracetamol concentration was quite low, and certainly too low to be connected to the deceased's death.[166]

142. On the other hand, the tramadol was found in very high concentrations in the blood and liver, within the ranges that have been associated with death from tramadol intoxication and predict severe toxicity and a risk of dying from overdose. The toxicological analysis therefore confirmed recent overdose with tramadol (consistent with tramadol tablets found in the stomach contents) and was consistent with tramadol poisoning as a cause of death.[167]

143. Tramadol is an opioid drug, meaning that it is related to morphine and opium, but it is considered to be a safer drug than morphine as it is not as potent and doesn't have the same degree of toxicity as morphine. However, if people take too much tramadol it can still cause serious illness or even death. Symptoms of drowsiness, nausea, vomiting, agitation high blood pressure and elevated body temperature are described in overdosage. At higher doses, the patient may be comatose and experience suppression of breathing. Lethal suppression of breathing is less likely with this opioid than with other opiates, like morphine, but is still the main reason for death in overdosage. Epileptic seizures may also occur.[168]

144. Tramadol is found in the brand formulations of Tramedo, which was dispensed to Mr Hine and found in Mr Hine's bedroom after the death. Found at the time were 5 tablets of the Tramedo SR (sustained release) 200 mg formulation and one capsule of the Tramedo 50 mg formulation. The tablets were designed for sustained release (taking up to 12 hours to completely dissolve

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[163] T 16, 18; Exhibit 1, Tab 10 and Tab 26.
[164] T 56.
[165] Exhibit 1, Tab 6.
[166] T 57.
[167] T 57; Exhibit 1, Tab 6 [21] – [22].
[168] T 56 - 57; Exhibit 1, Tab 6 [18].

and providing a relatively steady release of tramadol over the last 8 hours of that period) and the capsules were designed to release their contents for rapid absorption into the body (commonly dissolved within 15 minutes of digestion and showing their presence in the circulation within 20 or 30 minutes of ingestion).[169]

145. Professor Joyce noted in his report that four tablets were found in the deceased's stomach, with the design matching the Tramedo SR 200 mg tablets. No capsules were found in the stomach contents, but Professor Joyce noted that due to the fact capsules are designed to dissolve quickly, they would not be expected to be present in their original form for the same amount of time as the tablets.[170]The fluid in the deceased's stomach contents was measured for tramadol after the four tablets were removed and was found to contain a total of 100 mg of tramadol.[171] Professor Joyce also noted that it is not conventional forensic pathology practice to sample the small intestine, and it was confirmed it was not done in this case,[172] so there may well have been tablets down there as well that were not discovered.[173]

146. Professor Joyce was unable to say whether the deceased ingested one excessive dose of tramadol or a series of doses, including an excessive final dose. However, Professor Joyce could provide an opinion as to whether the deceased was likely to have taken more tramadol than the four tablets found in her stomach after death. The fact that the tablet markings were still present on the tablets found in the deceased's stomach suggested the tablets were still quite early in the 12 hour interval of digestion and had probably been ingested within a few hours before death.[174] Because most drug absorption actually occurs after the formulation leaves the stomach, Professor Joyce gave the opinion the levels found in the deceased's blood and liver, which he calculated to be about 300 mg of tramadol, and the tramadol in the fluid in the stomach contents, which was about another 100 mg, would require a greater degree of tablet disintegration than what was actually found. It follows that the deceased must have ingested more tramadol than the four undissolved tablets found in her stomach.[175]

147. This raises two possibilities. It is possible the deceased took some rapid release capsules at or around the same time as the four tablets, as they would dissolve more quickly and the highest concentrations would generally be achieved around an hour after being taken. This could account for the high levels of tramadol in the body and stomach contents. The other possibility is that there may have been an earlier ingestion of tramadol, either as tablets or capsules or both, followed later by the ingestion of the additional four tablets that were found in her stomach after death.[176]

148. As to what constituted a lethal dose for the deceased, Professor Joyce advised that as tramadol is not registered for use in children, at least in Australia, there is limited information on tolerable doses for a child. However, Professor Joyce indicated he would not anticipate that children would respond much differently from adults to the drug. Based on one adult case in Professor Joyce's own experience and another reported adult case, he suggested that for the deceased a lethal dose might have been as little as one to four 200 mg tablets (that is 200 mg to 800 mg), fully dissolved and absorbed, or other combinations of tablets and capsules that summed together to between 200 mg and 800 mg. Therefore, the four tablets found in the deceased's stomach were likely to have been a lethal dose for her, if there had been opportunity for them to dissolve fully, quite separate to any other amount of tramadol she ingested.[177]

[169] T 58; Exhibit 1, Tab 6.
[170] T 58; Exhibit 1, Tab 6 [8] – [9].
[171] T 56.
[172] T 75.
[173] T 67.
[174] T 59.
[175] T 59; Exhibit 1, Tab 6.
[176] Exhibit 1, Tab 6 [26].
[177] T 64; Exhibit 1, Tab 6, [29].

149. Based upon the discovery of the four largely undissolved tablets, together with the deceased's blood concentrations of tramadol, Professor Joyce felt that all the information pointed fairly consistently towards ingestion of the final dose of four Tramedo SR 200 mg tablets within about four hours before death.[178] The discovery of the tablets intact also suggested they were not crushed up or dissolved in fluid before being ingested, but must have been swallowed whole.[179]

150. The drowsiness and nausea reportedly seen on the day before her death was discovered was consistent with tramadol intoxication at that time. Professor Joyce indicated that it is common to find evidence of regurgitation or vomiting in people who have died of opioid toxicity.[180] If I assume that the drowsiness and nausea on the Sunday afternoon was related to the tramadol intoxication, which Professor Joyce appeared to consider was likely, then this also raises the possibility that there was more than one exposure to tramadol and the deceased was in recovery from earlier tramadol exposure when she ingested the four tablets. However, the other possibility is that she took all of the tramadol at the same time on the Sunday, and her time of death was much earlier than the time she was found in a lifeless state by Mr Hine.[181]

151. Professor Joyce agreed in his evidence that "it's really the time of death which is the thing and none of the pointers have got an absolutely unique interpretation there."[182] He commented that it would be difficult to reconcile the unabsorbed tablets in the stomach with one ingestion on Sunday and death in the middle of Monday, even acknowledging that there is extremely limited experiences of lethal tramadol overdoses in children. Therefore, the two main possibilities that remain open on the available evidence are that:[183]

- the deceased died around midday on Monday after taking a dose of tramadol sometime on Sunday and a second dose of tramadol (the four tablets) on the Monday morning; or
- the deceased took only one amount of tramadol, which included quick release capsules and the four slow release tablets, sometime in the early evening on the Sunday and died in the early hours of Monday morning.

152. Putting to one side Mr Hine's evidence that he believed he saw signs of the deceased being alive during the morning, and even at around midday on the Monday (which I will come back to later in this finding), Professor Joyce agreed that "the scenario of progressive opioid intoxication through the afternoon and evening and the death sometime during the night [late Sunday into early Monday morning] would seem fairly probable."[184]

153. I asked Professor Joyce about the likelihood of a small child taking a quantity of this type of medication of their own volition. He indicated that his current experience is with adults, not children. However, of the cases Professor Joyce could recall where he had been asked to comment on a child's death from poisoning, he could not think of any that involved anything other than a therapeutic drug. Professor Joyce noted that in most households the most poisonous things in the household are the medications and they are formulated in a manner which encourages people and children to think they are something to be eaten. Further, children will also have often been administered tablets or seen parents or caregivers taking tablets, "so there wouldn't be much reserve in a child's mind about experimenting with it."[185] Therefore, even

[178] Exhibit 1, Tab 6 [32].
[179] T 60 – 61.
[180] T 58.
[181] T 58 - 60; Exhibit 1, Tab 6 [23], [25] – [26].
[182] T 60.
[183] T 65 – 66.
[184] T 66.
[185] T 62.

though prescription medication tablets may generally have a foul taste, this would not preclude a child from taking them voluntarily.[186]

Additional evidence from Dr White

154. Dr White gave further consideration to any additional evidence that might shed light on the time of death after the inquest hearing. Dr White considered all of the post mortem examination findings, the neuropathology evidence and Professor Joyce's evidence, as well as the medical history from Wongan Hills hospital from the time of attempted resuscitation, which noted the deceased was lifeless on arrival with no pulse, cold to the touch (although no body temperature was taken) and cyanotic and showing rigidity at the hips/pelvis.[187] Dr White noted that the changes in the deceased's lungs "are likely to have evolved over some hours, at least 4-5 hours up to several before death, and are most likely to have developed overnight and progressed into Monday morning."[188] Dr White commented that it was possible the deceased had an evolving chest infection, which may have accounted for her illness on the Saturday night, and/or it is also possible she was showing signs of evolving tramadol toxicity on the Saturday night.[189]

155. Given all of the findings, Dr White expressed the opinion that if there was only one tramadol ingestion, it was most likely to have occurred earlier on the Monday morning, although Dr White was unable to give a specific time as to when the tramadol may have been ingested.[190]

Conclusion of the Homicide Investigation

156. As noted above, one particular focus of the homicide investigation was to determine whether there was any criminal culpability in the deceased's ingestion of the fatal quantity of tramadol. At the conclusion of the police investigation, Detective Sergeant Lewis formed the view that based on the available evidence there were three possible scenarios as to how the deceased ingested the tramadol.

157. The first possibility was that Mr Hine gave the deceased his tramadol medication and assisted her in taking the medication. It was found that there was no direct evidence that Mr Hine did so, and he made no admissions to that effect. Detective Sergeant Lewis noted that although Mr Hine did have a prior criminal record, he had no documented history of harming the children and did not appear to have any motive to deliberately harm the deceased.[191]

158. Although it is not mentioned by Detective Sergeant Lewis in his report, there remained the possibility that Mr Hine gave the deceased the medication not to deliberately harm her, but rather on the mistaken basis that it would not be harmful to her and might perhaps help her with her symptoms. In that regard, I note that Mr Hine denied giving her any tramadol medication. Further, Mr Hine, who was an adult, was only prescribed one slow release tablet per day. I can see no likelihood that he would have given her a minimum of four times his daily dose of the slow release tablets, all around the same time, simply with the intention of medicating her. That is not to mention the likelihood that she took more tramadol tablets, either the short acting ones at the same time or more slow release tablets.

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[186] T 61 – 62.
[187] Exhibit 6, Letter from Dr White to the Coroner dated 25 March 2021.
[188] Exhibit 6, Letter from Dr White to the Coroner dated 25 March 2021, p. 2.
[189] Exhibit 6, Letter from Dr White to the Coroner dated 25 March 2021, p. 2.
[190] Exhibit 6, Letter from Dr White to the Coroner dated 25 March 2021, p. 2.
[191] Exhibit 1, Tab 9, p. 17.

159. Detective Sergeant Lewis considered another possibility was that one of the deceased's two brothers, who were also in the home, gave the deceased the tramadol and/or helped her to access it and ingest it. Neither made any admissions to having done so when interviewed by police and there was no evidence to suggest this occurred.[192] In his evidence, Mr Hine indicated he did not want to even contemplate this as a possibility.

160. The third possibility identified by Detective Sergeant Lewis was that the deceased found the tramadol and ingested it without assistance from any other person. Detective Sergeant Lewis concluded the evidence suggested the deceased had access to the medication (as they were left unsecured in the bedroom where she slept) and enquiries had suggested that she had the dexterity to open the medication blister packs and consume the tablets/capsules. This was confirmed in interviews with other family members. The deceased also had the opportunity to do so unobserved, as she was left unsupervised in the room for various periods.[193]

161. Ultimately, Detective Sergeant Lewis concluded that, based on the available evidence, it could not be proven how the deceased ingested the tramadol, but there was no evidence that Mr Hine was criminally culpable for her death.[194] Senior Constable Michael Procopis, who gave evidence at the inquest in relation to the investigation, indicated that the police had no outstanding investigative strategies or avenues they felt could be explored that might shed further light on the matter.[195]

My Conclusion as to the Manner of Death

162. In addition to his various accounts given to police, Mr Hine also complied with his summons and gave evidence at the inquest. His account was largely consistent with the earlier accounts he had given. He denied giving the deceased any medications in the days leading up to her death, other than possibly letting her have a small sip of Lemsip, and directly refuted any suggestion he gave her tramadol. He had been taking tramadol again since injuring his wrist in May 2017, so he accepted it was possible he had taken tramadol around this time, although he could not recall specifically.[196]

163. On the Sunday, JHD went out during the day and the two younger children stayed in the lounge room watching cartoons. He recalled the deceased vomiting a small amount that evening but he "didn't think at any point that she was really, really ill."[197] He gave her some water in a cup and had another small vomit a bit later before going to bed.[198] The bedroom she went to sleep in had Mr Hine's tramadol medications out and accessible on the tallboy. He acknowledged he had become "a bit lazy on putting it back"[199] out of reach in the lock box he had purchased. He also acknowledged, in hindsight, that the deceased could have climbed the tallboy drawers (noting in the kitchen she would sometimes push a chair around to reach the kitchen bench) and reached the medications, although he did not realise she had done so at the time. He said if he had realised, he would have taken her straight to the hospital.[200]

164. Mr Hine gave evidence that it was a "complete shock"[201] when he found out the deceased had died from tramadol poisoning and he had "given it very, very deep thought on a daily basis ever

[192] Exhibit 1, Tab 9, p. 17.
[193] T 17; Exhibit 1, Tab 9, p. 17.
[194] Exhibit 1, Tab 9, p. 17.
[195] T 18.
[196] T 133 – 134, 139, 145.
[197] T 136.
[198] T 137.
[199] T 138.
[200] T 137 – 139, 145.
[201] T 146.

since."[202] He had considered the various alternatives the police had suggested were open on the evidence, and he indicated he knew he had not given her the tramadol and he did not want to contemplate any of the other children being involved, so he has focussed on accepting that the deceased took the tramadol herself.[203]

165. Mr Hine agreed that the evidence was most consistent with the deceased taking the tramadol on the Sunday afternoon or evening, as he couldn't see it occurring on the Monday morning as she did not get out of bed. Mr Hine also acknowledged that it was possible that in the morning, when he thought he had checked on the deceased and seen signs she was alive, he was mistaken and, in fact, she had already died by that time.[204]

166. The weight of the evidence points most strongly towards an accidental death as a result of the deceased accessing the tramadol herself, but it is not to the standard at which I feel satisfied to make that finding. Therefore, I make an open finding as to how the death occurred.

167. In terms of timing, the evidence supports the possibility the deceased ingested the tramadol sometime late in the afternoon or early evening of the Sunday and then began to show symptoms of tramadol toxicity in the form of vomiting and staggering, before she was put to bed. However, there is also a possibility she was developing a chest infection that afternoon, which was the cause of her symptoms, and ingested the tramadol sometime on the Monday morning, at a time when Mr Hine was unaware she was awake. In either case, after taking tramadol, the deceased became heavily sedated and over a number of hours developed pneumonia, before she died in the early hours of Monday morning. By the time Mr Hine realised she was showing no signs of life, it would appear she had been deceased for some time.

COMMENTS ON SUPERVISION, TREATMENT AND CARE

168. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care. In the context of the deceased's death, I consider that the focus of my comments should appropriately encompass the decision to remove the deceased from her biological mother's case and place her in the case of Mr Hine, and the continuation of that placement up until the time of her death.

169. The Department of Communities were represented at the inquest and two staff members from the Department gave evidence at the inquest, in addition to a very detailed report provided by the Department following the death setting out the factual chronology of the Department's dealings with the deceased and her family. This greatly assisted me to consider the appropriateness of the decisions made and the overall supervision, treatment and care of the deceased by the Department. Much of the factual background set out above in this finding comes from the Department's factual chronology.

Information from KD and LD

170. I was also assisted by information provided by the deceased's mother, KD, in relation to her dealings with the Department prior to the death. KD expressed the opinion that the Department did not adequately assess Mr Hine's level of risk to the children nor respond to safety concerns raised about the level of his care whilst they were with him.[205] I have considered carefully KD's

[202] T 146.
[203] T 147.
[204] T 142.
[205] Exhibit 1, Tab 13, p. 1.

concerns when assessing the adequacy of the supervision, treatment and care, acknowledging her understandable grief and anger at losing her child at a time when she had been removed from her mother's care purportedly for her own safety, and yet she was not kept safe.

171. The deceased's grandmother, LD, also expressed concern both before the deceased's death, and after her death, about the level of monitoring of Mr Hine by the Department. LD acknowledged that she and her daughter had agreed to the deceased and SD going to live with Mr Hine, on the basis the children could then be kept together, but she believes the Department were well aware of Mr Hine's past history of drug use and criminal behaviour, which she submits should have led them to check him more often and supervise his care of the children more closely.[206]

172. KD and LD participated in a meeting with Department staff, including the Assistant District Director and Ms Crawford, on 27 September 2017, as LD and KD had a lot of questions still around the case management of the children. Ms Crawford was still the case manager for the family and she arranged the meeting. At the meeting KD and LD expressed their concerns about the lack of regular monitoring of Mr Hine's care of the children by the Department leading up to the death. They indicated they had both felt concerned about Mr Hine's care of the children prior to the deceased's death but they had withheld some of their concerns from the Department as they had not wanted the children to be removed from Mr Hine's care and moved to foster care, which might have delayed the reunification process.[207] They were understandably angry with Mr Hine but they apparently both indicated at that stage that they did not believe Mr Hine would have intentionally harmed the children.[208]

173. KD also provided information to the Court stating that she and her mother had told Department staff that things were not good with Mr Hine, but their concerns were not acted on. KD had suspected drug use, as she and Mr Hine had a history of using drugs together in the past and she believes she saw him on one visit and recognised the signs that Mr Hine was under the influence of speed and was told concerning information by one of the children.[209]

174. LD provided information to the court that when she had expressed some concern about Mr Hine's ability to cope with the children after he broke his wrist, she was informed that the allocated case worker was fairly new and still in training. LD spoke to the new case worker at one stage and told her that things weren't right at the house and suggested she do a visit, but the case worker said she couldn't do it for a few weeks. LD says she was sitting in her car and she cried when she heard this as the house was an absolute mess despite her efforts to keep it clean, she was concerned the children were not being properly supervised in his care and she felt desperate for something to be done. Now, after the deceased's tragic death, she understandably holds Mr Hine and the Department responsible for her death as she believes the Department should have acted on her concerns and she believes Mr Hine should have checked on the deceased and feels he was negligent in his care of her.

Response to concerns raised by KD and LD

175. Ms Crawford gave evidence that if Mr Hine had admitted illicit drug use when she had questioned him about it then she would have escalated the matter.[210] However, he denied the allegations at the time, and agreed to undertake urinalysis, so it was unclear whether there was any truth to the allegations. Ms Crawford agreed at the inquest that the allegations made by KD on 11 July 2017 in any event warranted a standard of care assessment, but it was not something

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[206] Exhibit 1, Tab 15.
[207] T 45.
[208] T 45; Exhibit 2, Tab 1, SC82.
[209] Exhibit 1, Tab 13 and Tab 14.
[210] T 48.

she had done before and she understood it would usually be done by a Team Leader or placement officer in any event. Ms Crawford also agreed that to a certain extent, the arrangement for Mr Hine to undergo urine analysis was the start of a standard of care assessment.[211]

176. As noted above, there was historical involvement between the Department and the deceased's family before the deceased's birth. The family had first come to the attention of the Department in 2009, with regular domestic violence incidents between KD and a previous partner (not Mr Hine nor the deceased's father, BW). Further, there were six reported family and domestic violence incidents between the deceased's mother KD and father BW in the couple of years before she was born. There also appear to have been three reported family and domestic violence incidents in 2015 between KD and Mr Hine, with the complainant being Mr Hine. However, immediately prior to the deceased's death, there had been significant improvements in KD's lifestyle and the Department was working towards imminent reunification of the family.

177. Following the death, the Department immediately commenced a safety and wellbeing assessment inquiry into Mr Hine's care of the children. Neglect was substantiated in relation to the deceased on the basis that "Mr Hine had made little effort to check her temperature and determine how unwell she was and what care and medication she required in the days preceding her death and on the day of her death he had failed to ascertain if she needed toileting, bed changing, pain relief, food or water."[212] This conclusion was reached prior to the outcome of the post mortem examination. On 23 October 2017 the Department was advised out of the outcome of the autopsy relating to the tramadol found in the deceased's system at the time of her death.

178. Neglect was not substantiated in relation to the two other children at the time of the initial inquiry immediately following the death.[213] However, the following day SD was placed with KD, initially with the supervision of his grandmother and then this was varied on 24 August 2017 to permit KD to care for him without her mother's supervision.

179. On 20 April 2018 the Department initiated a further safety and wellbeing assessment following the children disclosing physical abuse and a lack of supervision when living with Mr Hine. On 1 March 2019 the Department finalised the assessment, noting inconsistencies in the children's reports prior to, and post, the deceased's death and the possibility that the children's interviews may have been influenced by their interactions with others post her death. Neglect and physical abuse were not substantiated in relation to AHD, who had left Mr Hine's care in early 2017, but the likelihood of neglect was substantiated for JHD and SD based on their sporadic school attendance, which academically disadvantaged both children. No physical abuse was substantiated, although it was felt Mr Hine probably employed inappropriate discipline in the form of smacking and yelling. Ultimately, it was assessed that Mr Hine had prioritised his own needs over the children's education. A concern was also raised about his use of illicit drugs while a registered carer.[214]

180. Further, in relation to the deceased, in addition to the findings above, it was concluded that the death may very well have been prevented if Mr Hine had complied with the Department's policy to store the tramadol in a locked box and been more vigilant and sought medical care for her at an earlier stage.[215]

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[211] T 53.
[212] Exhibit 1, Tab 12A, p. 29.
[213] Exhibit 1, Tab 12A, p. 29.
[214] Exhibit 1, Tab 12A, p. 30.
[215] Exhibit 1, Tab 12A, p. 30.

181. I am advised that the requirement was for the children to be seen by the Department at least every three months, which were known as quarterly reviews, as well as having a care planning meeting once a year, which could take the place of a quarterly review.[216]

182. Home visits to Mr Hine's home needed to be arranged by the Armadale Office, which remained the relevant office for the case due to the plans for reunification of the children with KD, who lived in Armadale. Wongan Hills was about a three hour drive from Armadale, so visits to his home were planned as impromptu visits were not practical.[217]

183. Department staff appeared to have accepted the deceased was regularly attending daycare, without making independent checks, as the later account from the daycare provider showed.[218] When Mr Hine was asked about this in a meeting with Department staff after the death, he said he would keep the deceased at home if the other children were sick, and also stated that he suffered from depression and sometimes he would be sleeping and would not get the children off to their school or daycare as a result. He was asked if he had told the case worker if he was struggling at that time, to which he did not respond.[219]

184. Ms Crawford accepted in her evidence that, knowing what she does now, there "was clearly a standard of care assessment that needed to be initiated" prior to the deceased's death, but she did not have the experience, nor the relevant information, at the time to understand that this process needed to be commenced.[220] Ms Crawford explained that there were placement officers who managed the family carers and the children had already been placed with Mr Hine before she became involved in the case, so she had not been involved in any of the background checks or other consideration of Mr Hine's carer assessment. However, she agreed that when concerns were raised, it was necessary for them to be considered and managed, which did not occur.[221]

185. A senior staff member for the Department of Communities', Mr Mace, whose position I set out below, agreed in oral evidence that his preference would have been for some action to be taken more quickly, and preferably within about a week of the allegations by KD, rather than the three weeks before even a conversation was had with Mr Hine. However, he also agreed that the fact Mr Hine had then agreed to undertake urinalysis provided some reassurance at the time.[222] Mr Mace also felt that more could have been done when it became apparent in early 2017 that the daycare attendance and school attendance of the children was sporadic, particularly as it came into Easter and June 2017. Mr Mace suggested a more proactive approach was warranted to try to understand in detail what was going on for Mr Hine and the children as there were a number of red flags.[223]

Standard of Care review in 2019

186. In early 2019 Department staff undertook a carer review and completed a Standard of Care report following information provided by the children AHD, JHD and SD during the investigation into the deceased's death. A Department staff member spoke to Mr Hine by telephone on 8 March 2019 for the purpose of completing this review. At this stage, Mr Hine was no longer a Departmental carer.

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[216] Exhibit 2, Tab 1 [25].
[217] Exhibit 2, Tab 1 [36].
[218] Exhibit 2, Tab 1, SC80.
[219] Exhibit 2, Tab 1, SC81.
[220] T 28.
[221] T 28 - 29.
[222] T 99 – 101.
[223] T 102 - 103.

187. Mr Hine was asked about the lengthy absences of the children from school and daycare at the inquest. He advised that the absences were to some degree associated with health issues, but were also linked to his compensation payout for a back injury. In March or April 2017 he gained access to the money and, since he had become depressed about the environment in Wongan Hills, the payout gave him the financial means to spend more time away from the town. Mr Hine gave evidence he spent the majority of the money on staying with the three children JHD, SD and the deceased at the Crown Towers (staying for a period of six to seven weeks) and also at restaurants, and they were absent from school at those times. Mr Hine maintained that the children were happy and well cared for by him until the deceased's tragic death. However, he also admitted to struggling to care for them following his wrist fracture. He accepted that he did not report this to the Department, but felt that they should have known.[224]

188. Mr Hine admitted to occasionally smacking the children on the bottom to correct their behaviours, despite knowing the Departmental guidelines indicated that children in care were not to be smacked, but that he rarely did it with SD and the deceased.[225]

189. Prior to the deceased's death, her mother had raised concerns with the Department that Mr Hine was using illicit drugs. He had been questioned about the allegation, and denied it. It had been intended to arrange for him to undergo urinalysis, but it does not appear this had eventuated prior to the deceased's death. Mr Hine admitted when questioned as part of the carer review in 2019 that he had been smoking small amounts of cannabis and on occasions using methylamphetamine at night time when the children were asleep. He maintained that his illicit drug use did not impact on his care of the children.[226] In his evidence at the inquest, Mr Hine indicated that he had rarely used illicit drugs while the deceased was alive. He said his significant relapse into illicit drug use only occurred after the deceased's death.[227] However, he did consume alcohol at night once the children were asleep and he accepted that it may have played a part in the way he responded to the children when in his care.[228]

190. In relation to the deceased's access to his medicine, Mr Hine said that he had obtained a locked medication cabinet, but nevertheless the tablets had been kept in his bedroom on top of the tallboy. He did not believe the deceased was capable of climbing up to the top of the tallboy at the time and he also did not think she would willingly take tablets as she had not liked taking them in the past. However, he was not able to elaborate on how she would have come to take the tramadol, nor the Lemsip, as he did not give them to her and he did not believe the other children would have given them to her. He accepted in hindsight that she could have made her way to the top of the tallboy.[229]

Changes to Policy and Practice since the death

191. Mr Glen Mace, Executive Director for State-wide Services for the Department of Communities gave evidence at the inquest to speak to the conduct of the Department and the changes made by the Department since the deceased's death. Mr Mace was not directly involved in any decision-making in relation to the deceased or her family so his evidence was based upon a review of the departmental records and his knowledge of current procedures and policies.[230]

192. It was clear Ms Crawford felt that she was disadvantaged in managing this particular case due to the geographical distance between where the children were living and where Ms Crawford

[224] T 125 - 126; Exhibit 1, Tab 12C.
[225] Exhibit 1, Tab 12C.
[226] Exhibit 1, Tab 12C.
[227] T 126 – 127.
[228] T 127 – 129.
[229] Exhibit 1, Tab 12C.
[230] T 84.

and the children's mother were based.[231] Mr Mace acknowledged that from his review of the file he could see how, with hindsight, the geographical distance between the Armadale District office and the children's home in Wongan Hills was a challenge for the Armadale District staff.[232] Mr Mace noted that the issue had been identified early on, and there were discussions between the Armadale office and the Northam District office (which was geographically the closest to Wongan Hills) about a transfer of the case, but the Northam office refused the transfer request from Armadale. The Professional Practice Unit was then asked to make the final call on the issue and a decision was made to leave the case with the Armadale office, on the basis they were working towards reunification with the mother, who remained living in Armadale.[233]

193. It was suggested that the Armadale District staff should have been able to utilise the Northam District staff to conduct a spot check at Mr Hine's home when concerns were raised. Ms Crawford agreed it could have been done at the time but she was guided by her Team Leader and the suggestion was not made. She was simply asked to make a phone call to organise a visit by the Armadale District team, which is what she did.[234] Mr Mace still felt the decision to leave the children with the Armadale District Office was correct, given the focus on reunification and the fact only a time limited order was in place and Mr Hine had indicated an intention to return to Perth. However, there were challenges of distance and geography, so some practical 'on the ground' help from the Northam office would realistically have been the best solution. Mr Mace gave evidence that since that time, there has been an improvement in cooperative case management, so he would expect the Armadale and Northam offices to be better able to work cooperatively to ensure practical assistance could be provided in a similar case. Mr Mace gave evidence that it is now expected that calls for assistance from another district office "are taken on."[235]

194. The Department advised in a report that it has implemented a range of practice improvements since the deceased's death. The changes include changes to the investigative process of Safety and Wellbeing Assessments, which have been renamed as Child Safety Investigations as part of the implementation of the new child protection investigation process. Additional resources have also been added to the Department's relevant District team and the quality and frequency of the staff's supervision and training has been increased.

195. Importantly, since August 2017 the Armadale District has introduced a number of initiatives to better train and manage carers. The District now has eight Senior Child Protection Worker-Placement Services, with an additional 24 FTE positions, which has reduced the number of carers managed by each worker from approximately 150 to 70, so a reduction of more than half, and also reduced significantly the number of cases being managed overseen by the team leaders. Each team also has an allocated case support officer position to help the team to complete administrative tasks and reduce the carers' paperwork burden.[236]

196. There is also a specific fortnightly support and training group for Non-Aboriginal carers that care for Aboriginal children (which would have applied to Mr Hine in relation to the deceased and SD, whose father was of Aboriginal descent). Further, in 2018 the District, in conjunction with Telethon Kids Institute, developed the in-depth therapeutic approach *Connect Caregiving* program, which is designed to support carers to better manage and support children in care to recover from trauma, which also would likely have applied to SD and the deceased, given the violence background from which they were removed.[237]

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[231] T 46.
[232] T 90.
[233] T 91.
[234] T 51 – 52.
[235] T 106, 111 - 112.
[236]T 105 - 106; Exhibit 1, Tab 12A, p. 34.
[237]T 105; Exhibit 1, Tab 12A, p. 34.

197. In a supplementary report, the Department advised that further changes have been made since March 2020, in particular changes to the way in which Standard of Care Concerns are investigated, including an explicit direction that the child's views should be sought and considered, and consideration of the inclusion of school non-attendance as a potential signifier of neglect warranting further investigation.[238]

198. In my view, the proposed changes in relation to escalating action where there is repeated non-enrolment or non-attendance at school is important. Indeed, it may have altered the course of events in this case, as there were major issues in terms of school attendance for JHD and particularly SD, which under such a policy change would have prompted a closer look by the Department at Mr Hine's suitability as a carer. Similarly, the increased focus on monitoring childcare attendance and following up absences as soon as possible might have made a difference in the deceased's case.[239]

199. Mr Mace gave evidence that the Department also now encourages the case manager to have a more conversational educational discussion with carers about poisons and medications, starting off by outlining the prevalence of accidental poisoning and overdose, particularly in young children, to ensure that the appropriate message is conveyed about why the Department has safe storage requirements for medications and poisons.[240] The requirements themselves are encapsulated in the Safe Storage of Alcohol and Other Poisons policy document, which emphasises that across Australia, "unintentional poisoning is the second largest cause for hospital admission in young children under 5 years of age,"[241] with the most common causes of poisoning being medicines, cleaning products and everyday items such as perfume.[242] Safety measures to keep such items out of reach are then detailed in the policy, with an acknowledgment that every home and circumstance is different, so the risk assessment should consider the individual circumstances.

200. Further, Mr Mace explained that the way the care teams in district offices are structured has changed so that placement teams no longer exist and the role of providing carer support has been brought within the children in care teams. Therefore, the one team leader now has oversight of both the requirements of the carer and the needs of the children. Every one of the eight care teams currently working in Armadale now has a dedicated full-time placement support officer, which allows better support to be provided to carers and also better governance and management of the carers.[243] Mr Mace noted that this arrangement provides a better opportunity for the carers and placement support staff to do joint work and joint planning together, which is a quite different approach to what was in place in 2017.[244]

201. In terms of assessing the safety of the home, Mr Mace indicated that the annual care review includes a requirement that the case manager be satisfied that the accommodation meets all of the requirements for the placement, and considers all aspects and dimensions of the children's lives, but they do not necessarily take place in the family home. There ought to have been an annual review for the deceased and her siblings in April 2017, a year after she went into care, but it was not signed off by the District Director until July 2017 and does not appear to have occurred before her death. Mr Mace was unaware of the reason for the delay in this case. [245]

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[238] Exhibit 1, Tab 12B.
[239] Exhibit 1, Tab 12B.
[240] T 92.
[241] Exhibit 1, Tab 12D, p. 1.
[242] Exhibit 1, Tab 12D, p. 1.
[243] T 94 – 95.
[244] T 96.
[245] T 98 – 99.

202. Ms Crawford described herself as "inexperienced" and indicated when she started she had no training, but was largely learning on the job. She had the support of her team leader but it generally required her to take the initiative and consult her team leader seeking direction, rather than being supervised closely.[246] She was, in effect, thrown in the deep end and she suggested it would have been preferable to have completed her training before she started and then been teamed up with another case manager to assist in tutoring her as she learnt the role in a more formalised process, rather than being largely left to her own resources to seek help when needed.[247] Mr Mace indicated that the Department has developed its support and training for new staff since 2017, so that new staff have to have completed the first two levels of induction before they can case manage and they have a reduced case load until they have passed their probation period. There is then additional training to be completed, with a total of four levels of induction provided overall. There is still a process of tasks being given to the trainee case managers by the team leader, but the process is drawn out over a longer period.[248]

203. Finally, after acknowledging the burden that was placed upon the children's grandmother, LD, to support both Mr Hine and her daughter, KD, when things were going downhill, Mr Mace noted that since 2017 there are reunification services through the intensive family support teams who are contracted service providers that might assist in a similar situation, although even with those services the focus is usually on the home where the children are hoping to be returned to after reunification, rather than the temporary placement home.[249]

Concluding comments on supervision, treatment and care

204. Mr Hine gave evidence that he did not blame anyone else for what happened to the deceased but he agreed in hindsight that he had taken on too much. Although he did his best at the time, he was struggling to cope and should have asked for more help. He believes if he had been offered help by the Department, in the form of domestic support, he would have open to accepting, but it did not occur to him to ask for more help at the time. In hindsight, he accepts it was his failure to keep the medications out of reach that created an unsafe situation and if there was anything he could do now to go back and change it, he would.

205. I note LD has provided some information that suggests she blames herself for not agreeing to take the children from Mr Hine that night when he asked. There is no way that anyone could have expected any more from LD than what she did. She had been a major support for both her daughter and Mr Hine in looking after the children, and she was torn in two directions, separated by long distances, at a time when Mr Hine was struggling but her daughter was heavily pregnant and in need of assistance. She tried to pass on her concerns about Mr Hine's ability to cope with the Department, and the state of the house, but it did not lead to the action she hoped for and then it was too late. LD says she has a photo in her kitchen window and speaks to the deceased every day to tell her she loves her and is sorry.[250] I hope LD can come to accept that none of this was her fault and that she was, and I'm sure still is, a wonderful grandmother who did her best.

206. As for the Department of Communities, I am satisfied that there were missed red flags that should have prompted a more proactive approach to assessing Mr Hine's ongoing suitability to care for the children while removed from their mother's care, and either a consideration to provide him with more support or to remove the children and place them elsewhere. As it was, the remaining children were immediately taken from Mr Hine's care and returned to their mother, as the reunification process was well advanced, so this might well have been an option

[246] T 27 – 28.
[247] T 49.
[248] T 96 - 97.
[249] T 104.
[250] Letter to the Court from LD received 17.2.2021.

prior to the deceased's death. I accept that there were some unusual challenges faces in this particular case, particularly for a new case manager in lengthy training faced with geographical obstacles, so I make absolutely no criticism of the individual case manager. My concern is with the Department of Communities' management of the case as a whole.

207. In my view, the supervision of Mr Hine's care of the children by the Department was below the appropriate standard expected by the community. I understand the focus was on the mother's suitability to have the children returned to her, and that her allegations against Mr Hine were untested and made in a conflictual context, but the grandmother, LD, had also been regularly raising concerns and she had shown herself to be an honest and dedicated caregiver so her concerns should have prompted action much sooner than occurred in this case. There were also the concerns raised by the school in relation to the other children, which if properly explored might have led to a better appreciation of Mr Hine's difficulties and the need to urgently revisit the placement and/or provide additional supports to ensure the children were in a safe and appropriate environment. Mr Hine admits he wasn't coping, and if someone had actually gone to his house and spoken to him, I believe it would have been obvious.

208. The difficulty was that there was a major geographical obstacle to any kind of impromptu visit by the Armadale District office staff, and the Northam office had initially been reluctant to take over the case, so it may have been felt that they would be resistant to assisting. In any event, they were not asked, and this led to a delay in anyone speaking to Mr Hine and no face to face contact with him. The willingness to rely upon family members to bear the load of the long trips between the mother's home and placement home, was also part of the problem, putting Mr Hine and LD under additional stress. The last weekend of the deceased's life clearly demonstrates this, noting the lateness of the transfer in the cold winter evening, which perhaps gave Mr Hine some reason to dismiss the signs that something was wrong on the basis she might be tired and suffering a cold.

209. With the benefit of hindsight, it is clear that there were serious red flags about the suitability of the placement with Mr Hine in the months leading up to the deceased's death, but there were a number of reasons why they were not acted upon in a timely manner. While I do not place blame at the feet of any individual, I accept the evidence given on behalf of the Department of Communities that the concerns raised by KD and LD should have been acted on sooner, and there was a missed opportunity to intervene in the case and possibly prevent the death.

CONCLUSION

210. The deceased has been described by her grandmother as 'everyone's little sunshine'. She was a happy little girl, full of energy, and loved to dance and sing. Her grandmother recalls fondly making cupcakes together and going to the park and even enjoying time together on the long car trips to visits with her mother. Her mother remembers the deceased's fighting spirit as a newborn and how smart and cuddly she was as a child. Her mother and grandmother and siblings are grief stricken at her loss.

211. They have raised many questions about the standard of care that was provided by Mr Hine, and apparently condoned by the Department, which led to a little girl's preventable death from a prescription drug that she should never have had been able to access. While we remain unsure of the circumstances of how she came to ingest the tablets, they will always have unanswered questions.

212. While I am satisfied that there is no evidence the deceased's death occurred due to the deliberate conduct of any person, the evidence is still unclear as to what exactly occurred. The most likely scenario is that she took a quantity of the tramadol tablets on the day before her death was

discovered, given she was seen staggering and vomiting the night before, at least 12 hours before she was taken to hospital in a lifeless state, and the expert evidence indicates the four tablets found in her stomach at the time of her death had probably only been ingested in the four hour window before she died. How she came to take those tablets remains unknown.

213. It is well known that toddlers are vulnerable to accidental poisoning in the home when medications are not kept safely out of reach. The Australian website 'Raising Children', which is supported by the Australian Government's Department of Social Services, warns that medicines are the most common cause of poisoning in young children, which is why parents and other carers are advised to store all medicines out of reach and out of sight in a cabinet or cupboard with a child resistant lock.[251] The photographs taken at the scene, shortly after the death, show clearly that this practice was not followed by Mr Hine as his prescription medications were left out on the bedside table, easily accessible to the deceased who was sleeping unsupervised in his bedroom prior to her death. She clearly had opportunity to take them without anyone knowing, and this is certainly a strong possibility.

214. This case is a tragic example of why adults are warned to keep dangerous and hazardous items out of reach of small children, and the need for vigilant supervision when they are not. It is also important that caregivers are alert to the possibility that events such as this can occur, and to obtain immediate health advice when children appear unwell for no obvious reason. It is also important to monitor them closely, not simply leave them to sleep for more than 12 hours. Mr Hine accepts that he should have done more to ensure that the deceased was living in a safe home environment, and I have no doubt he regrets his failure every day, but his regret cannot undo the harm that has been done.

215. The correspondence I have received from the deceased's mother, KD, and grandmother, LD, clearly shows their deep pain, grief and anger. They place blame on Mr Hine and the Department, which is understandable. The deceased was taken away by the Department for her own safety, and yet she was placed in an environment that ultimately proved to be unsafe for her and she died as a result. Her mother and grandmother had tried to raise concerns but no one listened until it was too late. Mr Hine had complained that his children were not safe with KD, and yet he did not keep KD's daughter safe. The little family has now been reunited, but without one important member and the newest family member never got to meet his sister.

216. KD has indicated in a letter to the Court that she takes some comfort in the fact that the Department of Communities has made a large number of changes to their policies and procedures, and significantly increased staffing resourcing and structure, since the deceased's death. While it will not bring her daughter back, it is important that she is able to take away the message that lessons have been learnt.

S H Linton
Coroner
16 April 2021

[251] https://raisingchildren.net.au/toddlers/safety/poisons/medicines-that-can-poison accessed 8.1.2021.