[2025] WACOR 57

JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA

ACT : CORONERS ACT 1996

CORONER : BRENDYN DEAN NELSON, CORONER

HEARD : 10 DECEMBER 2025

DELIVERED : 22 DECEMBER 2025

FILE NO/S : CORC 113 of 2023

DECEASED : CHILD LK

Catchwords:

Nil

Legislation:

Children and Community Services Act 2004 (WA)
Coroners Act 1996 (WA)

Counsel Appearing:

Mr W Stops assisted the Coroner

Mr E Panetta (Panetta McGrath) appeared on behalf of Dr R Cresp

Ms K Niclair (State Solicitor's Office) appeared on behalf of the Department of Communities and Western Australian Country Health Service

Mr S Pack (instructed by Clyde & Co) appeared on behalf of Lifestyle Solutions (Aust) Ltd

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Brendyn Dean Nelson , Coroner, having investigated the death of **Child LK (name suppressed)** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 10 December 2025, find that the identity of the deceased person was **Child LK** and that death occurred **on or about 24 August 2023** at **'Pegasus' Family Group Home, McKail** from **epilepsy in a boy with Influenza B and COVID-19 infections** in the following circumstances:*

Table of contents

Introduction ... 4
Issues raised at the inquest ... 5
Materials received at the inquest ... 5
Materials received after the inquest ... 6
Factual findings ... 8
Child LK's personal background ... 8
Child LK's entry into the care of the CEO of the Department ... 8
Child LK's living arrangements while in care ... 9
Lifestyle Solutions ... 10
Background of Child LK's health ... 12
Child LK's history of seizures between October 2022 and June 2023 ... 14
Child LK's consultation with Dr Cresp ... 20
Child LK's seizure on 14 August 2023 ... 22
Events of 23 August 2023 ... 23
Emergency response ... 24
Cause and manner of death ... 25
Treatment, supervision, and care of Child LK ... 26
Management of Child LK's seizures ... 26
Treatment provided by WACHS ... 26
Consultation with Dr Cresp ... 26
Appropriateness of the categorisation of Child LK's referral ... 27
Child LK's re-presentations to the AHC ED ... 28
Departmental approach to Child LK's seizures ... 29
Lifestyle Solutions' support of Child LK's treatment ... 30
Missed appointments ... 32
CAMHS appointment on 20 July ... 32
Further appointment with Dr Cresp on 7 August 2023 ... 34

Did the Department inform Lifestyle Solutions of the appointment? .. 34
Was Lifestyle Solutions aware of the appointment, otherwise?........... 37
Should the need for a further review have been apparent, notwithstanding? 37
Consequence of the appointment not occurring 39
Improvements since Child LK's death *40*
Communication between the Department and Lifestyle Solutions*........... *41
Referral to YPECN* *43
Conclusions 44

<u>SUPPRESSION ORDER</u>

Suppression of:

**(1) The deceased's name from publication and any evidence likely to lead to the child's identification.
The deceased is to be referred to as Child LK**

(2) The names of the deceased's siblings from publication and any evidence likely to lead to the identification of the deceased's siblings.

(3) The names of the children in the care of the CEO, residing at the Lifestyle Solutions care home in McKail during the time Child LK resided in the care home, and any evidence likely to lead to the identification of those children.

Order made by BD Nelson, Coroner (10/12/2025)

Introduction

1 Child LK was a 14-year-old boy who died suddenly on or about 24 August 2023 after suffering an unwitnessed epileptic seizure, precipitated by viral infections.

2 Child LK was described as a cheerful and playful boy, who had endured a traumatic past.[1] He enjoyed skateboarding, dirt-bike riding,[2] going to the beach and fishing,[3] and wanted to work as an electrician[4] in the mining industry when he finished school.[5]

3 Child LK had been diagnosed with epilepsy in June 2023 after a history of seizures in the preceding eight months. He was adhering to a medication regime prescribed by a specialist paediatrician, with the support of those caring for him. Sadly, his treatment, and the efforts of his carers, could not prevent the tragic and entirely unexpected outcome.

4 Child LK was in the care of the Chief Executive Officer (**CEO**) of the Department of Communities (**Department**) at the time of his death, and therefore a person held in care for the purposes of the *Coroners Act 1996* (WA) (the **Act**).[6]

5 As such:

(a) his death was reportable;[7]

(b) a coronial inquest was mandatory;[8] and

(c) I am required to comment on the quality of the supervision, treatment and care that Child LK received while in care.[9]

6 From 15 September 2022 until his death, Child LK was residing at a family group home in McKail as part of a care arrangement between the Department and a private organisation, Lifestyle Solutions (Aust) Ltd (**Lifestyle Solutions**).

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[1] Exhibit 1, tab 13, par [17].
[2] Exhibit 2, tab 1, par [4.10].
[3] Ts 39.
[4] Ts 51.
[5] Exhibit 1, tab 17, p 12.
[6] The Act, s 3 (par (a)(i) of the definition of 'person held in care').
[7] The Act, s 3 (par (e) of the definition of 'reportable death').
[8] The Act, s 22(1)(a).
[9] The Act, s 25(3).

7 Lifestyle Solutions refers to the group home where Child LK was living as 'Pegasus'. I adopt that name in these findings.

Issues raised at the inquest

8 The coronial inquest occurred on 10 December 2025.

9 In addition to the cause and manner of his death, the inquest focused on issues concerning Child LK's supervision, treatment and care, including:

(a) the response of the Department and Lifestyle Solutions to the seizures that Child LK experienced in 2022 and 2023;

(b) Child LK's medical treatment in relation to the same;

(c) the reasons for, and the Department and Lifestyle Solutions' responses to:

(i) Child LK's appointment with Child and Adolescent Mental Health Services (**CAMHS**) on 18 July 2023 being rescheduled to 20 July 2023, and then missed by Child LK; and

(ii) Child LK's follow-up appointment with the specialist paediatrician at Albany Health Campus (**AHC**) on 7 August 2023 being missed by Child LK;

(d) related to (c) above, the quality of communication between the Department and Lifestyle Solutions in relation to Child LK's ongoing medical care, particularly in July and August 2023; and

(e) the Department's decision-making in relation to a potential referral of Child LK to the State Government inter-agency Young People with Exceptionally Complex Needs program (**YPECN**).

Materials received at the inquest

10 In order to make the necessary findings under the Act, and to address the issues identified above, I received the documentary evidence in the coronial brief and an additional exhibit tendered by Lifestyle Solutions.

11 The following witnesses also gave oral evidence:

(a) Dr Rebecca Cresp, Consultant Paediatrician and Head of the Integrated Paediatric Service at AHC (operated by the WA Country

Health Service (**WACHS**)), who saw Child LK at an outpatient appointment on 26 June 2023;

(b) Ms Susana Vergara Belmar, a former employee of Lifestyle Solutions and one of Child LK's live-in carers at Pegasus;[10]

(c) Mr Mark Branson, Lifestyle Solutions' Chief Operating Officer (Child & Family Services), who gave evidence including in relation to the comprehensive internal review of Child LK's death;[11] and

(d) Mr Glenn Mace, the Department's Executive Director Service Delivery South, Child Protection and Family Support, who gave evidence in relation to the Department's internal review, as well as his detailed report on Child LK's time in care.

12 Dr Cresp, WACHS, the Department and Lifestyle Solutions were all represented by counsel at the inquest.

13 At my invitation, counsel for the Department and WACHS, and counsel for Lifestyle Solutions, made brief oral submissions at the end of the oral evidence in relation to what findings and comments I should make as to Child LK's care, treatment and supervision.

Materials received after the inquest

14 Ms Tanae McKnight, the Departmental Child Safety Practitioner allocated to Child LK prior to his death, was summonsed to give evidence at the inquest. Prior to the inquest, for reasons which do not need to be disclosed and upon her provision of a supplementary witness statement which addressed specific queries of the Court, her summons was discharged.

15 At the end of the inquest, and given the evidence that had been adduced including orally, I caused counsel assisting to write to Ms McKnight, to invite her to make any further submission in relation to a specific issue, addressed below at par [254]ff.

16 Ms McKnight made a submission by letter dated 19 December 2025. The letter contains both submissions and new evidence, which I am prepared to accept notwithstanding it is not contained in a signed witness statement.

17 I will address the additional evidence, and the content of Ms McKnight's submissions, when making findings about the relevant issue, below.

[10] Exhibit 1, tab 9, p 4.
[11] Ts 67.

18 The Department also sought leave to make a written submission in relation to the issue. A submission was filed, with leave, on 19 December 2025. I have reviewed those submissions and, given the conclusions I have reached, it is unnecessary to set them out in any detail; save for one aspect.

19 At par [3], the Department stated that it was:

> …concerned about procedural fairness to Ms McKnight, in circumstances where having received Ms McKnight's supplementary statement, the Court did not issue an adverse letter to Ms McKnight until after the inquest was heard.

20 This submission is surprising for several reasons, including that:

(a) the submission is made by the Department, and not by the person to whom procedural fairness has (supposedly) been denied;

(b) the Court facilitated Ms McKnight's involvement (both prior to and after the inquest) in a manner which was responsive to the matters contained in her request for her summons to be discharged;

(c) relatedly, before acceding to Ms McKnight's request for her summons to be discharged, the Court sought a supplementary statement that clearly identified the issue and afforded Ms McKnight the opportunity to adduce any evidence in relation to the same;

(d) s 44(2) of the Act provides that before making any adverse finding, the person must be given the opportunity to present submissions against the same – which is expressly what the Court did by inviting a submission from Ms McKnight after the inquest; and

(e) to the extent it is submitted[12] that the timing of the Court's letter precluded Ms McKnight exercising her rights under s 44(1) of the Act, no actual prejudice has been identified by the Department (nor, with respect, could it be identified given the ample notice and opportunities afforded by the Court, pre-emptively, to Ms McKnight (and the Department) to adduce any available evidence relevant to the issue, and the opportunity to Ms McKnight to make submissions).

21 For those reasons, I do not accept the Department's 'concern'.

22 Separately, even though she has not made any corresponding submission, I am satisfied that Ms McKnight has been afforded procedural fairness.

[12] Department's written submissions dated 16 December 2025, par [36].

Factual findings

23 In this part of the findings, I make factual findings about the circumstances leading up to and including Child LK's death, including any findings necessary to make comment on the matters identified at par [8] above.

Child LK's personal background

24 Child LK was born on 26 November 2008 in Kalgoorlie.[13]

25 He had two older siblings born to his parents,[14] as well as four maternal half-siblings and two paternal half-siblings.[15]

26 Child LK's family are Aboriginal, with his maternal family from Yamatji Country across the Murchinson, and his paternal family from Wangkatha Country in the Eastern Goldfields.[16]

27 He identified himself as a 'Wongi boy'.[17]

Child LK's entry into the care of the CEO of the Department

28 Child LK was taken into the provisional protection and care of the CEO pursuant to s 37 of the *Children and Community Services Act 2004* (WA) (the **Act**) on 5 March 2009,[18] at three months of age, on the bases of neglect and his parent's mental health and drug use.[19]

29 The Department's child safety investigation was finalised on 18 March 2009, which recorded that harm due to neglect had been substantiated.[20]

30 At the time of his death, Child LK was the subject of a protection order until 18 years of age, which had been made on 13 September 2011.[21]

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[13] Exhibit 1, tab 9, p 5.
[14] Exhibit 1, tab 9, p 5.
[15] Exhibit 1, tab 14, p 1.
[16] Exhibit 1, tab 14, p 2.
[17] Exhibit 2, tab 1, par [4.10]. I understand that 'Wongi' is a more informal way of referring to Wangkatha language peoples.
[18] Exhibit 1, tab 14, p 2.
[19] Exhibit 1, tab 8, pp 2-3.
[20] Exhibit 1, tab 14, p 4.
[21] Exhibit 1, tab 14, pp 5.

Child LK's living arrangements while in care

31 Child LK had 28 living arrangements whilst in care, including long and short-term care arrangements.[22]

32 It is unnecessary to set out a detailed chronology of those placements, which are summarised in Mr Mace's report.[23]

33 Many of the living arrangements were not the result of a formal placement by the Department, but arose due to Child LK 'self-selecting' where he wanted to live at the time.[24]

34 In February 2017, Child LK self-selected to live at a residence in Kalgoorlie where one his older brothers had been residing with a friend, cared for by the friend's mother (**RW**).[25]

35 The Department commenced a carer assessment of RW and her partner.[26]

36 In March 2017, RW advised the Department that she and her partner intended to move to Albany and wanted to take Child LK with them. Child LK wanted to move to Albany with RW.[27]

37 Departmental staff determined it would be in Child LK's best interest to relocate with RW.[28]

38 Child LK's placement with RW continued for several years.

39 Unfortunately, despite the best efforts of RW, Child LK's care arrangement with RW broke down irretrievably in late August 2020.[29]

40 On 2 September 2020, Child LK self-selected to live with a friend of RW who also lived in Albany (**TE**).[30]

41 TE was prepared to care for Child LK and this placement was successful for a significant period of time.

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[22] Exhibit 1, tab 14, p 5.
[23] Exhibit 1, tab 14, pp 5-7.
[24] Ts 82-83.
[25] Exhibit 1, tab 14, p 6.
[26] Exhibit 1, tab 14, p 13.
[27] Exhibit 1, tab 14, p 13.
[28] Exhibit 1, tab 14, p 13.
[29] Exhibit 1, tab 14, p 17.
[30] Exhibit 1, tab 14, pp 17-19.

42 However, again, despite best efforts, Child LK's care arrangement with TE broke down irretrievably in August 2022.[31]

43 On 24 August 2022, the Department emailed a referral regarding Child LK to Lifestyle Solutions.[32]

Lifestyle Solutions

44 Lifestyle Solutions is a private organisation that provides services and support for, amongst others, children and young people throughout Australia – including by provision of support in out-of-home care.[33]

45 In 2011, Lifestyle Solutions entered a contract with the Department to provide live-in carers for children in remote Western Australian communities under the 'Family Group Home' program. The arrangement continues today, with carers employed by Lifestyle Solutions living in properties owned and maintained by the Department.[34]

46 On 7 September 2022, Lifestyle Solutions agreed to a care arrangement for Child LK.[35]

47 Child LK's final care arrangement, at Pegasus, commenced on 15 September 2022.[36]

Child LK's time at Pegasus, generally

48 Despite his initial reluctance to live at Pegasus, Child LK eventually developed a positive relationship with his carers there.[37]

49 The rapport between Child LK and Pegasus staff necessarily took time to develop, and was the result of sustained effort by his carers.[38]

50 At the time of his passing, Child LK was living at Pegasus with four other children, as well as a live-in carer.[39]

[31] Exhibit 1, tab 14, p 24.
[32] Exhibit 1, tab 14, p 24.
[33] Exhibit 2, tab 1, par [3.14].
[34] Exhibit 2, tab 1, par [3.19].
[35] Exhibit 2, tab 1, par [11.3].
[36] Exhibit 1, tab 8, p 3.
[37] Exhibit 2, tab 1, par [4.8].
[38] Exhibit 2, tab 1, par [4.8].
[39] Exhibit 1, tab 11, p 39; tab 13, pars [8]-[11].

51 Ms Vergara Belmar was employed by Lifestyle Solutions in that role,[40] having performed the role for five years, three of which were at Pegasus.[41]

52 Ms Vergara Belmar shared the full-time live-in carer role at Pegasus with another carer. She would work 24 hours a day for seven days, then have seven days off.[42]

53 The carer working the corresponding seven-day shift during the time Child LK was at Pegasus was usually sourced from an agency.[43]

54 A support worker would attend Pegasus to assist the live-in carer, but usually only for 17 hours a week, and not on Sundays or public holidays.[44]

55 As a consequence, Ms Vergara Belmar was Child LK's primary and most consistent caregiver for the entirety of his time at Pegasus.[45]

56 Mr Branson observed, in his report, that young people in out-of-home care usually present with higher physical and mental health needs compared to their peers.[46] I accept this evidence. Child LK often behaved in a way which would have been challenging for Pegasus staff, including by absconding,[47] smoking cannabis,[48] and engaging in risk-taking behaviours that are typical of adolescence.[49]

57 I also infer, based on various traumas in his childhood and his complex physical and mental health issues, that assisting Child LK day-to-day would have been a demanding role for any caregiver.

58 However, it was clear, not least from her impressive oral evidence, that Ms Vergara Belmar developed a deep understanding of Child LK, and was positive about his progress and future.

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[40] Exhibit 1, tab 13, pars [2], [4].
[41] Exhibit 1, tab 13, pars [5]-[6].
[42] Exhibit 1, tab 13, par [7].
[43] Ts 36.
[44] Ts 38. The number of hours of support worker attendance at Pegasus had increased, substantially, by mid-2025 - to around 50 hours of support per week: ts 38.
[45] Exhibit 1, tab 13, pars [15]-[16]; ts 36-37.
[46] Exhibit 2, tab 1, par [3.28].
[47] Ts 44.
[48] Ts 43.
[49] Exhibit 2, tab 1, par [4.11].

59 For example, in 2023, Child LK was attending Alta-1, an educational institution that provides alternative education programs for disengaged and at-risk students.[50] Child LK was doing very well in this program,[51] attending consistently,[52] and was looking forward to the prospect of returning to mainstream school.[53]

60 Ms Vergara Belmar also gave evidence about how, despite absconding from Pegasus regularly, Child LK was always in communication with her about his welfare,[54] and he demonstrated a responsible approach to his medication regime after being diagnosed with epilepsy.[55]

Background of Child LK's health

61 Detailed summaries of Child LK's healthcare while in the care of the Department are outlined in the reports prepared by Mr Mace, and Mr Branson. The following matters of significance in relation to the management of Child LK's mental health are drawn from those reports, as well as other medical records which form part of the coronial brief.

62 I will deal with Child LK's seizures, and his consultation with Dr Cresp in relation to the same, in separate sections of these findings, below.

63 In May 2021, Child LK attended an appointment with a psychiatrist from CAMHS, accompanied by Departmental staff.

64 The psychiatrist suggested that Child LK was experiencing trauma and post-traumatic stress disorder (**PTSD**), with underlying depression. The psychiatrist prescribed the anti-depressant medication escitalopram and indicated that counselling should be part of Child LK's treatment.[56]

65 In a letter dated 24 May 2021, the psychiatrist diagnosed Child LK with severe depressive disorder, and stated that other diagnoses, including PTSD and attention deficit hyperactivity disorder (**ADHD**), would be evaluated in future.[57]

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[50] Exhibit 2, tab 1, par [4.17].
[51] Ts 51.
[52] Ts 39.
[53] Ts 52.
[54] Ts 42; 45.
[55] Ts 43.
[56] Exhibit 1, tab 14, p 41.
[57] Exhibit 1, tab 18, p 10.

66 Child LK attended another psychiatric review on 14 June 2021 during which his prescription medication was increased.[58]

67 Child LK attended a further psychiatric review in early August and was prescribed medication to assist with his sleep.[59]

68 On 23 December 2021, CAMHS advised the Department that Child LK had an ADHD assessment booked in January 2022, however they intended to close Child LK's case until then. There is no evidence that such an assessment took place, or that Child LK was ever formally diagnosed with ADHD, or PTSD.

69 I interpose that I am satisfied, on the basis of Dr Cresp's evidence, that a formal diagnosis of either condition would not have materially changed Dr Cresp's approach to treating Child LK's epilepsy in June 2023.[60]

70 CAMHS saw Child LK again on 27 February 2023, at which time he presented as irritable, angry and dysthymic.

71 No acute risks were identified, but it was recommended that following paediatric review, if Child LK were willing, his medications could be recommenced through his GP.[61]

72 On 6 April 2023, a Departmental district psychologist recommended that as Child LK had complex needs and because he was at significant risk of harm to himself, a referral to YPECN would be appropriate so that he could receive more intensive, wrap-around support and management.[62]

73 In a consultation on 29 June 2023 between the district psychologist and Ms McKnight, it was noted that because Child LK's presentation was 'stable' and there was a reduction in his risky behaviours, it was agreed that any referral to YPECN would be held, 'for now' and at least until CAMHS had completed their assessment.[63]

74 I will return to that decision, and Mr Mace's evidence in relation to the same, at par [304]ff below when I consider the issue of whether a YPECN referral should have been made sometime before Child LK's death.

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[58] Exhibit 1, tab 18, p 22.
[59] Exhibit 1, tab 18, p 29.
[60] Ts 33.
[61] Exhibit 1, tab 14, p 48; tab 19, p 209.
[62] Exhibit 1, tab 14, p 49; tab 19, p 250.
[63] Exhibit 1, tab 19, p 321.

75 On 30 June 2023, CAMHS emailed the Department regarding Child LK's upcoming appointment on 18 July.[64]

76 The same day, Ms McKnight emailed Lifestyle Solutions about the 18 July appointment with CAMHS.[65]

77 On 5 July 2023, CAMHS sent the Department a further notification letter regarding the appointment.[66]

78 On 17 July 2023, Ms McKnight emailed Lifestyle Solutions reminding them of Child LK's appointment with CAMHS the following day.[67]

79 Lifestyle Solutions confirmed receipt.[68]

80 On 18 July 2023, a Lifestyle Solutions carer called CAMHS and advised that Child LK would not get out of bed, and would not be attending the appointment. The carer and CAMHS agreed to reschedule the appointment to 20 July 2023, at 2pm. A SMS text message was sent to the carer, confirming the date and time of the rescheduled appointment.[69]

81 Child LK's carer emailed Ms McKnight on 18 July, indicating that Child LK had been difficult to wake up that day.[70]

82 Child LK did not attend the CAMHS appointment on 20 July.

83 The possible reasons for his non-attendance are addressed at par [231]ff below.

84 Child LK did not have another appointment with CAMHS before his death.

Child LK's history of seizures between October 2022 and June 2023

85 Child LK experienced seizures, and seizure-like symptoms, on many occasions from October 2022 and before seeing Dr Cresp in June 2023.

86 In making the following findings about the course of Child LK's seizures and the medical care provided to him before his consultation with

[64] Exhibit 1, tab 19, p 329.
[65] Exhibit 1, tab 22.1, par [70].
[66] Exhibit 1, tab 19, p 331.
[67] Exhibit 1, tab 14, p 54.
[68] Exhibit 1, tab 22.2, par [7].
[69] Exhibit 1, tab 24.
[70] Exhibit 2, tab 1, par [7.5].

Dr Cresp, I have relied primarily on the contemporaneous records of AHC, the Department and Lifestyle Solutions.

87 Those records do not always accord with the chronology contained in Ms Vergara Belmar's witness statement, provided to police on the day of Child LK's death. Where there is apparent conflict between the documentary record and Ms Vergara Belmar's recollection on matters of chronology, I have preferred the documentary record.

88 This should not be understood as any criticism of Ms Vergara Belmar or her evidence. Her witness statement was fulsome and, on any view, impressive in its detail given it was provided:

(a) on the same day she had discovered Child LK after his fatal seizure and rendered emergency first aid; and

(b) seemingly, without the benefit of access to any records.

89 It was obvious during her oral evidence that Ms Vergara Belmar still has an accurate, independent recollection of many matters of significance concerning Child LK and his history of seizures and epilepsy diagnosis.

90 I also interpose that any findings I make regarding Child LK's seizures should not be understood as critical of Ms Vergara Belmar, or any carers.

91 As Mr Branson observed, Child LK's carers received first aid training, but were not medically trained – their role was to provide residential support and therapeutic care, not clinical treatment.[71]

92 It was fortunate for Child LK that Ms Vergara Belmar had, by chance, completed Epilepsy Essentials training (through Epilepsy Action Australia) in January 2020.[72]

93 According to Ms Vergara Belmar, Child LK's first seizure occurred when he was at a friend's home and was observed by the friend's mother to have fainted, before shaking.[73]

94 Ms Vergara Belmar recalls the friend's mother calling her, and Ms Vergara Belmar instructing her to call an ambulance.[74] Ms Vergara

[71] Exhibit 2, tab 1, par [3.28].
[72] Exhibit 2, tab 1, par [6.5(c)].
[73] Exhibit 1, tab 13, par [20]; ts 40.
[74] Exhibit 1, tab 13, pars [20]-[21].

Belmar says she met Child LK at AHC, where he was checked and discharged with no follow-up.[75]

95 For reasons outlined below at par [99], I find that Child LK's first documented admission to AHC for a seizure (on 4 October 2022) is the second episode referred to in Ms Vergara Belmar's witness statement, not this first episode.

96 There is no record of any admission of Child LK to AHC before 4 October 2022 for seizure-like symptoms. This has been confirmed by solicitors acting for WACHS in this inquest.[76]

97 Given the absence of any record of an admission at AHC for Child LK for seizure-like symptoms prior to 4 October 2022, I find that:

(a) sometime prior to 4 October 2022, Child LK suffered an episode at a friend's home and was observed by the friend's mother to have fainted, before shaking, and that this event was communicated to Ms Vergara Belmar at some stage;

(b) however, Ms Vergara Belmar is likely mistaken in her recollection about an admission of Child LK to AHC on this very first occasion.

98 In her witness statement, Ms Vergara Belmar refers to a second incident, where Child LK was at another friend's home, when that friend's mother called Ms Vergara Belmar to report that Child LK was unconscious and having 'attack or a seizure'.[77]

99 I find that this second episode occurred on 4 October 2022, because:

(a) Ms Vergara Belmar recalls that she returned to the AHC Emergency Department with Child LK 'the following day' after this second episode, because he was experiencing a really bad headache;[78]

(b) Ms Vergara Belmar recalls that she demanded that a blood test and MRI be performed on this return visit to the AHC Emergency Department, and that the tests were performed but did not demonstrate any abnormal results;[79]

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[75] Exhibit 1, tab 13, pars [22]-[23].
[76] Email from Ms K Niclair, State Solicitor's Office to Mr W Stops, Counsel Assisting, dated 16 December 2025.
[77] Exhibit 1, tab 13, pars [24]-[25].
[78] Exhibit 1, tab 13, pars [36]-[37].
[79] Exhibit 1, tab 13, pars [38]-[39].

(c) there are contemporaneous records from the Department, Lifestyle Solutions and WACHS that establish that on 7 October 2022 Child LK returned to the AHC Emergency Department with ongoing headache, and had an MRI and blood tests;[80] and

(d) there is an AHC Emergency Department discharge summary from 4 October 2022[81] that accords with the recollection of the second episode contained in Ms Vergara Belmar's witness statement.

100 During this second episode on 4 October 2022, Ms Vergara Belmar told the friend's mother to call emergency services, and Ms Vergara Belmar attended the home herself immediately.[82]

101 She could see that Child LK had bitten his tongue.[83]

102 Paramedics attended and conveyed Child LK and Ms Vergara Belmar to AHC, where doctors performed some tests.[84]

103 Ms Vergara Belmar's recollection was that she asked for blood tests to be taken during this admission on 4 October 2022, but none were performed prior to Child LK being discharged.[85]

104 I find, based on the discharge summary, that an attempt was made to take blood, but that Child LK pulled his arm away. A paediatric registrar was consulted, and it was agreed that it was safe for Child LK to return home.[86]

105 Such findings are consistent with the Departmental report which records that Child LK refused to have his blood taken for testing and attempted to leave the hospital.[87]

106 On 5 October, a Departmental officer visited Child LK at Pegasus. He agreed to attend a GP appointment, with the earliest available booked for 12 October. A Safety Plan was developed with Lifestyle Solutions.[88]

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[80] Exhibit 1, tab 18, p 35; tab 14, p 43; exhibit 2, tab 1, par [11.8]
[81] Exhibit 1, tab 18, p 33.
[82] Exhibit 1, tab 13, pars [26]; ts 40-41.
[83] Exhibit 1, tab 13, par [30].
[84] Exhibit 1, tab 13 pars [32]-[33].
[85] Exhibit 1, tab 13, pars [33]-[34].
[86] Exhibit 1, tab 18, p 33.
[87] Exhibit 1, tab 14, p 43.
[88] Exhibit 1, tab 14, p 43.

107 As identified above, Child LK presented to AHC again on 7 October 2022, with a continuing headache.

108 Diagnostic testing including blood tests and MRI was undertaken, with results to be sent to the GP for a follow-up appointment.[89] The examination of Child LK was normal, and the treating doctor indicated that his headache was likely due to the prior seizure. The doctor recommended plenty of fluids, rest, and Panadol, as required.[90]

109 Subsequent attempts to have Child LK attend appointments with a GP were unsuccessful due to his refusal, or his leaving due to wait times.[91] Difficulties with getting Child LK to see a GP also arose because of the GP needing to reschedule appointments due to extended waiting times, and cancellation of an appointment by the GP for unspecified reasons.[92]

110 Ms Vergara Belmar estimates that Child LK was experiencing one to two seizures every month between January and May 2023.[93]

111 Child LK had poor sleep habits at this time and would often stay up all night and sleep in lesser amounts during the day.[94]

112 Ms Vergara Belmar believed, due to his appearance and behaviour, that Child LK was smoking cannabis often.[95]

113 On 26 January 2023, Child LK advised staff at Pegasus that he believed he had experienced a seizure during sleep.[96]

114 On 6 February 2023, Child LK had a seizure while at his friend’s home. He was taken to hospital by ambulance, and presented as aggressive and refusing treatment.[97]

115 Child LK’s presentation on this occasion was particularly challenging for medical staff, with his behaviour no doubt a result of the confusion and fear he was feeling at this time.[98]

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[89] Exhibit 2, tab 1, par [11.8].
[90] Exhibit 1, tab 14, p 43.
[91] Exhibit 1, tab 14, pp 43-44.
[92] Exhibit 2, tab 1, par [11.9]-[11.10].
[93] Exhibit 1, tab 13, pars [40]-[41].
[94] Exhibit 1, tab 13, par [42].
[95] Exhibit 1, tab 13, par [43].
[96] Exhibit 2, tab 1, par [11.13].
[97] Exhibit 1, tab 14, p 45.
[98] Ts 42.

116 A code black was called, but staff were able to de-escalate the situation, and the treating doctor was able to take Child LK's observations and a history. Child LK reported feeling like he had had multiple seizures while asleep at night since October 2022.

117 The treating doctor spoke with a neurologist at Perth Children's Hospital, who recommended a referral to a paediatrician and that an electroencephalogram (**EEG**) be performed in Albany.

118 The treating doctor made a referral to AHC's paediatric service, and a referral to CAMHS.[99] The doctor discharged Child LK with a plan regarding pain relief and recommended that there be follow up with Child LK's GP to assess progress of the referrals that had been made.[100]

119 The referral to the paediatric service was categorised as a category 2, with a wait time of 3-6 months.[101]

120 I consider the appropriateness of this categorisation, including Dr Cresp's evidence in relation to the same, at par [188]ff below.

121 On 7 March 2023, Child LK attended the AHC Emergency Department as he had a headache and was concerned that he might have a seizure.[102]

122 He was assessed, and given ibuprofen. Following observation, he reported his headache was much improved and wanted to go home. Child LK and his carer were advised on signs that would warrant re-presentation.[103]

123 On 16 March 2023, Child LK had a seizure and was taken to the AHC Emergency Department by ambulance. He was noted to be uncooperative with assessment and occasionally verbally abusive. He was observed and another referral was made to the paediatric service.[104]

124 He was discharged home with a safety net.[105]

[99] Exhibit 1, tab 17, p 18.
[100] Exhibit 1, tab 18, p 38.
[101] Exhibit 1, tab 19, p 138.
[102] Exhibit 1, tab 14, p 48.
[103] Exhibit 1, tab 18, p 42.
[104] Exhibit 1, tab 17, p 15.
[105] Exhibit 1, tab 18, pp 44-45.

125 Child LK re-presented that night with vomiting and nausea on ongoing headaches.[106]

126 He was diagnosed with a viral illness and given anti-nausea medication.[107]

127 On 19 April 2023, the Department received an email from Amity Health confirming that Child LK had been booked for EEG on 26 April 2023.[108]

128 He attended that appointment,[109] and there were no epileptiform abnormalities on the awake and drowsy state recordings.[110]

129 Child LK had another seizure on 25 April 2023 at home. He did not want to attend the AHC Emergency Department for assessment.[111]

130 Child LK had another seizure on 7 June 2023. He was taken to AHC by ambulance, but chose to leave hospital after about 30 minutes.[112]

131 He was discharged against advice.[113]

132 Child LK had seizure-like symptoms on 20 June at home, but did not accept help and chose to attend Alta-1.

133 He subsequently agreed to attend hospital and remained for monitoring over the course of two hours,[114] but declined blood tests.[115]

Child LK's consultation with Dr Cresp

134 Child LK saw Dr Cresp on 26 June 2023.

135 Ms Vergara Belmar attended the appointment with Child LK, and observed that Dr Cresp was very thorough and performed an extensive consultation over two to three hours.[116]

[106] Exhibit 1, tab 18, p 18.
[107] Exhibit 1, tab 14, p 48.
[108] Exhibit 1, tab 14, p 50.
[109] Exhibit 1, tab 14, p 51.
[110] Exhibit 1, tab 18, p 18.
[111] Exhibit 1, tab 14, p 51.
[112] Exhibit 1, tab 14, p 52.
[113] Exhibit 1, tab 18, p 50.
[114] Exhibit 1, tab 14, p 53; tab 18, p 52.
[115] Exhibit 1, tab 18, p 53.
[116] Exhibit 1, tab 13, pars [48]-[50].

136 From Ms Vergara Belmar's perspective, Dr Cresp told her and Child LK everything that they needed to know. Dr Cresp clearly explained her initial plan to treat Child LK, including medication.[117]

137 Ms Vergara Belmar's observations about the thoroughness and clarity of the examination and the treatment plan are borne out by the detailed and comprehensive outpatient notes of Dr Cresp.

138 It is also evident that Dr Cresp provided concise and clear written instructions about the medication regime for the benefit of Child LK and his carers (including her contact details if any issues or questions arose),[118] and liaised directly with Ms McKnight two days after the consultation.[119]

139 In her report to the referring physician, and copied to the Department, Dr Cresp advised that Child LK had experienced seizures including a number which had been unprecipitated or unprovoked. The seizures were generalised tonic-clonic episodes. Dr Cresp noted that the results of the MRI and EEG were normal,[120] and that neurological, cardiovascular, respiratory, and abdominal examinations were all unremarkable.[121]

140 Dr Cresp commenced Child LK on an anti-epileptic medication, sodium valproate, on a dose of 200 mg 'bd' (meaning twice daily) for two weeks, increasing to 400 mg bd, and then 500 mg bd after six weeks.

141 At the inquest, Dr Cresp explained that she elected to commence Child LK on this particular anti-epileptic because it was 'broad-spectrum' in nature,[122] and because she was pre-empting (correctly) that Child LK may have taken medication historically for mental health disorders and this anti-epileptic medication would not make any mood disorder worse.[123]

142 Dr Cresp described the side effects of the anti-epileptic to Child LK and Ms Vergara Belmar, and what to do if any eventuated.[124]

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[117] Exhibit 1, tab 13, pars [52]-[54].
[118] Exhibit 1, tab 17, p 2.
[119] Exhibit 1, tab 16.
[120] Dr Cresp confirmed the same in her oral evidence at the inquest, and confirmed that the results of blood tests were also normal: ts 14.
[121] Exhibit 1, tab 17, p 12.
[122] Ts 20.
[123] Ts 17.
[124] Ts 21.

143 Dr Cresp also requested a full blood count and liver function testing to be collected after six weeks, and advised that she would review Child LK again as an outpatient at that time.[125]

144 Ms Vergara Belmar confirms that Child LK took the increasing dosages of sodium valproate twice daily as prescribed, once in the morning and once at night, and that she set up an alarm system to assist in reminding Child LK.[126]

145 Medication administration records created by Lifestyle Solutions confirm that Child LK was compliant with his medication regime between June 2023 and 23 August 2023.[127]

146 Child LK did not attend a follow-up appointment with Dr Cresp which had been scheduled by WACHS for 7 August 2023.

147 There is no direct evidence why Child LK did not attend.

148 My findings as to how and why the appointment on 7 August was missed are detailed below at par [248]ff below.

149 Given Child LK's non-attendance, Dr Cresp directed another appointment be booked into her clinic within four to six weeks, which is a standard approach she adopts for a child she considers to be at high risk.[128]

150 That appointment would have been the first available, given the frequency of the outpatient clinic and the existing bookings at the time.[129]

Child LK's seizure on 14 August 2023

151 Between his consultation with Dr Cresp on 26 June 2023, and his death on 23 August 2023, Child LK only presented to AHC due to a seizure, or potential seizure symptoms, twice.

152 Child LK presented to the AHC Emergency Department on 29 July 2023 with 'aura' symptoms. He was observed for four hours prior to a medical review, which concluded that he had normal vital signs and no seizure activity. Child LK reported he was feeling back to normal.[130]

[125] Exhibit 1, tab 17, p 13.
[126] Exhibit 1, tab 13, pars [58]-[60].
[127] Exhibit 2, tab 4, pp 23-31.
[128] Exhibit 1, tab 21, par [31].
[129] Ts 28.
[130] Exhibit 1, tab 18, p 59.

153 One 14 August 2023, Child LK experienced a seizure which, according to Ms Vergara Belmar, was the first since he had started medication.[131]

154 Child LK refused ‘BSL’ (which I take as a reference to a blood sugar level), and did not wait to be seen for a medical review.[132]

155 Ms Vergara Belmar was not at work at the time but spoke to Child LK on her return to Pegasus about this seizure. He denied having bad sleep or stopping his medication, and admitted that he had had ‘two cones’.[133]

156 Ms Vergara Belmar tried to reinforce that he should not be taking drugs especially because of his diagnosed epilepsy.[134]

157 Ms Vergara Belmar does not recall Child LK presenting with any flu-like symptoms following her return from leave.[135]

Events of 23 August 2023

158 Child LK spent the morning of 23 August 2023 with Ms Vergara Belmar and doing chores before he was collected at 1 pm by staff from Alta-1.[136]

159 Child LK returned home at about 4.30 pm.[137]

160 He told Ms Vergara Belmar that he had been at his friend’s place prior to coming home.[138]

161 He said he was hungry and appeared tired. Ms Vergara Belmar got him some snacks and asked if he had used cannabis.[139] He said that he had not, and Ms Vergara Belmar considered that he did not appear to be ‘stoned’, as she had observed in the past.[140]

162 At about 8 pm, Child LK ate the sushi that Ms Vergara Belmar had made for dinner. Ms Vergara Belmar recalled that he ate a fair bit.[141]

[131] Exhibit 1, tab 13, par [64].
[132] Exhibit 1, tab 18, p 62.
[133] Exhibit 1, tab 13, pars [66]-[73].
[134] Exhibit 1, tab 13, par [80].
[135] Ts 55.
[136] Exhibit 1, tab 13, pars [87]-[89].
[137] Exhibit 1, tab 13, par [91].
[138] Exhibit 1, tab 13, par [98].
[139] Exhibit 1, tab 13, pars [93]-[95].
[140] Exhibit 1, tab 13, par [97].
[141] Exhibit 1, tab 13, pars [106]-[108].

163 At about 9 pm, Ms Vergara Belmar gave Child LK a glass of orange juice along with his medication. At the time, he was playing on his phone in his bedroom.[142] He said that he was tired and was going to go to bed.[143]

164 Ms Vergara Belmar turned the light off and walked to the living room. She heard Child LK get up and lock his bedroom door.[144]

165 At about 10.30 pm, Ms Vergara Belmar knocked on Child LK's bedroom door and said good night. Child LK replied 'night'.[145]

166 Ms Vergara Belmar returned to the office (which functioned as the bedroom for the live-in carer).[146] She could not recall specifically, but says it was likely that she did paperwork before going to sleep.[147] She was not awoken for reason, including by Child LK, overnight.[148]

Emergency response

167 Ms Vergara Belmar woke up at 7 am on 24 August.[149]

168 At around 8.10 am to 8.20 am, Ms Vergara Belmar knocked on Child LK's door, but there was no answer which she thought was unusual because Child LK was normally awake by 7.30 am.[150]

169 Ms Vergara Belmar started to become concerned when Child LK did not get up from bed, so she went to her office to get keys and returned to Child LK's room. She knocked again and announced that she was coming in and unlocked the door with her keys.[151]

170 Ms Vergara Belmar observed Child LK was slumped off his bed. She attended to him immediately, but he was unresponsive.[152]

171 He was wearing the same clothes that he was wearing when he had gone to bed the night before.[153]

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[142] Exhibit 1, tab 13, pars [111]-[114].
[143] Exhibit 1, tab 13, par [115].
[144] Exhibit 1, tab 13, par [117]-[118].
[145] Exhibit 11, p 15; tab 13, pars [122]-[123].
[146] Ts 54.
[147] Ts 55.
[148] Ts 54-55.
[149] Exhibit 1, tab 13, par [125].
[150] Exhibit 1, tab 11, p 19; pars [131]-[133].
[151] Exhibit 1, tab 13, pars [134]-[136].
[152] Exhibit 1, tab 13, pars [138]-[143].
[153] Exhibit 1, tab 13, par [162].

172 Ms Vergara Belmar called emergency services at about 8.40 am,[154] and commenced CPR. She was limited to performing chest compressions, because Child LK's jaw was locked, and his nose was blocked.[155]

173 An ambulance was called at 8.45 am, and paramedics arrived at 8.52 am.[156] They took over from Ms Vergara Belmar and assessed Child LK. Paramedics determined that he was not breathing, had no pulse, and was in rigor.[157] He was declared deceased at 9 am.[158]

174 Police officers arrived at 9.15am,[159] and detectives attended shortly after to determine whether there was any criminality connected to Child LK's death.[160] Following their investigation, officers concluded that there was no evidence to indicate any criminality or suspicious circumstances.[161]

Cause and manner of death

175 Forensic pathologists conducted a post mortem examination on 31 August 2023. The pathologists identified petechiae and superficial injuries to the face and tongue that could result from a seizure/collapse-type event.[162]

176 Neuropathological examination found changes to particular brain structures which may be associated with epilepsy.[163]

177 Toxicological analysis detected the anti-epileptic medication valproate at therapeutic levels, and alcohol and tetrahydrocannabinol, the active component of cannabis, at unremarkable levels.[164]

178 Infectious screening detected the pathogenic COVID-19 and Influenza B viruses and an abundance of the bacterium *staphylococcus aureus* on a nasal swab. The Influenza B virus was also detected in the trachea and both lungs.[165]

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[154] Exhibit 1, tab 13, par [147]-[151].
[155] Exhibit 1, tab 11, p 20; tab 13, par [144].
[156] Exhibit 1, tab 10; tab 12, p 1.
[157] Exhibit 10, p 2.
[158] Exhibit 1, tab 2.
[159] Exhibit 1, tab 11, p 32.
[160] Exhibit 1, tab 9 p 2.
[161] Exhibit 1, tab 9, p 2; tab 11.
[162] Exhibit 1, tab 5, p 1.
[163] Exhibit 1, tab 5, p 2; tab 6.1, p 2.
[164] Exhibit 1, tab 5, p 2; tab 7.
[165] Exhibit 1, tab 5, p 2.

179 Biochemical analysis detected elevated creatinine levels, indicative of some kidney dysfunction.[166]

180 The pathologists observed that seizures can be life-threatening and can be precipitated by the physiological stress placed upon the body by concurrent infections like Influenza B and COVID-19.[167]

181 Following the further analyses, the pathologists formed the opinion that Child LK's cause of death was epilepsy in a boy with Influenza B and COVID-19 infections.[168]

182 Having regard to the evidence, including the medical records concerning Child LK's epilepsy symptomology, I respectfully agree with and adopt the forensic pathologists' conclusion as to the cause of Child LK's death as my finding for the purposes of s 25(1)(c) of the Act.

183 For the purposes of s 25(1)(b) of the Act, I find that Child LK's death occurred by way of natural causes.

Treatment, supervision, and care of Child LK

Management of Child LK's seizures

184 As identified above, two of the key issues addressed at the inquest were the approach taken by those responsible for Child LK's care and supervision to his seizure history, and the medical care provided to him concerning the same.

Treatment provided by WACHS

Consultation with Dr Cresp

185 I find that Dr Cresp's treatment of Child LK during the appointment on 26 June 2023, and her documentation of the same (both in the patient record, and for the benefit of Child LK and the carer) was exemplary.

186 The high quality of Dr Cresp's examination is reflected in Child LK – someone who despised attending medical appointments – remaining, and engaging, for the entirety of a long appointment.

187 I find that this positive outcome was the result of:

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[166] Exhibit 1, tab 5, p 2.
[167] Exhibit 1, tab 5, p 2.
[168] Exhibit 1, tab 5, p 1.

(a) Dr Cresp's considered approach during the consultation;

(b) Ms Vergara Belmar's work ahead of time to prepare Child LK for an appointment that she understood to be critical to his wellbeing;[169] and

(c) Ms McKnight's consideration of what she could do to best ensure Child LK's attendance.[170]

Appropriateness of the categorisation of Child LK's referral

188 I have considered whether the categorisation of Child LK's referral to the Integrated Paediatric Service as category 2 was appropriate.

189 At the inquest, Dr Cresp explained that the Integrated Paediatric Service uses a triage system where, once a week, any referrals are reviewed and prioritised at a meeting which usually includes at least two paediatricians, the clinical nurse, and an administrative officer.[171]

190 Dr Cresp has no recollection if she participated in the triage and categorisation of Child LK's case.[172] However, her evidence is that the categorisation of Child LK's case was appropriate on the basis of the known information,[173] including the lack of any indication of significant morbidity or mortality risk absent immediate clinical management.[174]

191 I accept Dr Cresp's opinion, including having regard to her experience and expertise in the triage of cases similar to Child LK's, both in the Great Southern region and at Perth Children's Hospital.[175]

192 I also infer that the categorisation was informed, in part, by the preference for an EEG to have been completed before any paediatric consultation, to maximise the utility of that appointment.[176]

193 As an aside, I note Dr Cresp's evidence that the Integrated Paediatric Service was relatively new at this time, and less well established within AHC as it is now.[177]

[169] Ts 46.
[170] Exhibit 1, tab 22, pars [60]-[61].
[171] Ts 12.
[172] Ts 13.
[173] Ts 13.
[174] Ts 12-13.
[175] Ts 14.
[176] Exhibit 1, tab 21, par [8]; ts 13-14.
[177] Ts 30.

194 As a consequence, I am satisfied that, notwithstanding the triage score initially allocated to any referral, there is a clear and well-known ability for the Service to be consulted by others at AHC, including clinicians in the Emergency Department, as required, including prior to any future outpatient appointment.

Child LK's re-presentations to the AHC ED

195 According to my findings above, Child LK presented to AHC on seven occasions in relation to seizures prior to his death.[178] The questions arises whether more should have been done (particularly during the later admissions) prior to the appointment with Dr Cresp.

196 Following Child LK's death, WACHS conducted a SAC 1 clinical incident investigation. In their report, the investigating panel observed, appropriately, that the unexpected death of a client with mental health concerns requires rigorous investigation, and recognised that Child LK's death was an important opportunity for a process and service review.[179]

197 The panel observed that in addition to the actions taken by clinicians at AHC on 6 February 2023, some additional actions may have been beneficial – including encouragement of an admission.[180]

198 The panel stated that Child LK's baseline level of risk (including his being in care, and his history of trauma including recognition of potential PTSD) could have provided a lower threshold for an admission.[181]

199 Having reviewed the documentation on the brief and having heard Dr Cresp's evidence, I agree with the panel's ultimate conclusions that:

(a) the care provided at each of Child LK's presentations to the Emergency Department was appropriate and adequate; and

(b) although each attendance at the AHC Emergency Department may have presented as an opportunity to admit Child LK for further investigation, his not being admitted was not contributory to his death and there was no indication at any presentation of the catastrophic outcome.[182]

[178] Exhibit 1, tab 9, p 6.
[179] Exhibit 1, tab 20, p 5.
[180] Exhibit 1, tab 20, p 6.
[181] Exhibit 1, tab 20, p 6.
[182] Exhibit 1, tab 20, p 6.

200 I draw the conclusion at (b), above, in part based on Dr Cresp's evidence that any longer admission would have likely involved post-seizure observation only, and may not have resulted in any change in treatment.[183]

201 I also question, based on the evidence demonstrating his aversion to medical appointments, whether Child LK would have acceded to a longer admission purely for observation.

202 I also rely on Dr Cresp's evidence that inpatient treatment is more likely when a patient is having 20 or 30 seizures a day,[184] and that death is a known but incredibly rare outcome from seizures.[185]

Departmental approach to Child LK's seizures

203 It is clear that Ms McKnight took a series of appropriate actions for the purposes of, and prior to, the consultation with Dr Cresp.[186]

204 Ms McKnight also took steps, both direct and indirect, to support the implementation of Dr Cresp's recommended treatment.[187]

205 I also find that Ms McKnight actively considered how she could incentivise Child LK's attendance at important medical appointments.[188]

206 I note that Child LK's difficulties with sleep, and his cannabis use, were known issues complicating the management of his epilepsy.[189]

207 I am satisfied, including having asked Mr Mace about this directly at the inquest,[190] that there were no other resources readily available that could have been employed by Ms McKnight to attempt to address these matters.

208 These issues would presumably have been addressed as part of the ongoing psychotherapy recommended by Dr Cresp, the organisation of which is addressed below in the context of the missed appointments.

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[183] Ts 29.
[184] Ts 28.
[185] Ts 16.
[186] Exhibit 1, tab 22, pars [52]-[60].
[187] Exhibit 1, tab 22, pars [61], [63]-[64], [71].
[188] Exhibit 1, tab 22, pars [29]-[30].
[189] Exhibit 2, tab 1, par [4.16].
[190] Ts 82.

209 The Department's internal review, the findings of which were adopted by Mr Mace at the inquest,[191] identified that the frequency of health care planning for Child LK during the review timeframe was not in accordance with relevant practice guidance and was well overdue.[192]

210 The evidence demonstrates that Ms McKnight was aware of the requirement, and seeking to action this in consultation with Lifestyle Solutions.[193]

211 I do not consider that the absence of the health care plan had any negative impact in this case, particularly given the regular medical treatment that Child LK was otherwise receiving in relation to his seizures.

212 I accept Ms McKnight's evidence that her capacity to attend to Child LK during his hospitalisations (or to organise another Departmental staff member to attend) was hampered by the timing of Lifestyle Solutions' provision of critical incident reports.[194]

213 Lifestyle Solutions advised Ms McKnight, at the time, that incident reports were not being sent in a timely manner due to unexpected staffing issues.[195] As such, there is no basis for any criticism of the Department or Ms McKnight in this regard.

214 Further, I am satisfied from the evidence of Mr Branson that the restructure of Lifestyle Solutions' operations (addressed below) will avoid a similar issue arising in future.

Lifestyle Solutions' support of Child LK's treatment

215 The evidence demonstrates that Lifestyle Solutions' staff:

(a) assisted Child LK with taking his medications;

(b) implemented measures to ensure compliance with medication; and

(c) regularly spoke with Child LK about his health including his seizures, and the importance of attending his medical appointments, good sleep hygiene, and abstaining from drug use.

[191] Ts 81.
[192] Exhibit 1, tab 15, p 11.
[193] Exhibit 1, tab 22.1, par [59].
[194] Exhibit 1, tab 22.1, pars [48]-[49].
[195] Exhibit 1, tab 14, p 51.

216 With Lifestyle Solutions' support, Child LK appears to have reached a stage where:

(a) he was taking his medication as prescribed, and was independently aware of the importance of his doing so;

(b) he was able to identify and verbalise pre-seizure or 'aura' symptoms and seek assistance; and

(c) his sleep hygiene had improved.[196]

217 It is also clear that Child LK understood he needed to try and minimise his use of cannabis.[197]

218 These outcomes are credit to Child LK, and to his carers.

219 It is apparent that Ms Vergara Belmar did her best to ensure that medical appointments were booked at times when she would be on duty, to enable her to consistently accompany Child LK.[198]

220 I accept that this *ad hoc* approach by Ms Vergara Belmar has now been formalised by Lifestyle Solutions through the creation of case manager and therapeutic specialist roles, as identified by Mr Branson.

221 I find that Pegasus displayed information from Epilepsy Action Australia about first aid for seizures, and seizure management and safety planning was discussed at a Pegasus staff team meeting in February 2023.[199]

222 Like the Department, Lifestyle Solutions' staff also appears to have used appropriate incentives to ensure Child LK's attendance at critical appointments.[200]

223 As part of its internal review, Lifestyle Solutions identified that an Epilepsy Management Plan was not obtained from the specialist as required by internal policy.[201] I do not consider that this non-compliance with policy had any significant negative consequence in this case.

[196] Exhibit 2, tab 1, par 4.16].
[197] Ts 43.
[198] Ex 46.
[199] Exhibit 2, tab 1, par [6.5(d) and (e)].
[200] Exhibit 2, tab 1, par [11.22]; ts 47.
[201] Exhibit 2, tab 1, par [12.5(a)].

224 The internal review also identified that seizure charts were not completed accurately, in that there was sporadic recording.[202]

225 While not ideal, I do not consider that this had any negative impact on the course of Child LK's treatment, and it certainly did not contribute to the tragic outcome.

226 In terms of further improvements since Child LK's death, I note that Lifestyle Solutions has engaged external clinical services which work with their therapeutic specialists to enhance the organisation's capacity to provide therapeutic and clinical advice to frontline staff.[203]

227 I anticipate that the availability of this resource will assist Lifestyle Solutions' staff in being able to provide advice and support to children like Child LK about positive behaviours surrounding their medical health.

Missed appointments

228 As identified above, there were two important health appointments missed by Child LK in, roughly, the month prior to his death – one with CAMHS, and one with Dr Cresp.

229 These missed appointments were a focus of the inquest, given there was no clearly documented reason either appointment had been missed.

CAMHS appointment on 20 July

230 There are no records of Lifestyle Solutions, the Department or CAMHS which address, directly, why Child LK did not attend the rescheduled appointment with CAMHS on 20 July 2023.

231 There are two inferences open on the available evidence.

232 The first is that, consistently with previous experience,[204] Child LK either refused to attend the appointment on 20 July, or Lifestyle Solutions were unable to take Child LK to the appointment for some other reason, such as him absconding and becoming uncontactable.

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[202] Exhibit 2, tab 3.1, p 16.
[203] Ts 69.
[204] Exhibit 2, tab 1, par 4[.15].

233 The second inference is that the appointment was overlooked by staff at Pegasus. Such an inference is capable of being drawn having regard to the evidence, from the time, that Lifestyle Solutions was experiencing staffing issues and were stretched.[205]

234 Mr Branson acknowledged that finding and retaining suitable staff was a significant challenge at this time.[206]

235 A fact that militates against the second inference is that the carer who organised for the rescheduling of the appointment on 18 July was the same carer who would have been on duty on 20 July.[207].

236 I accept that it is inherently unlikely that a staff member would overlook an appointment having rescheduled it themselves two days earlier.

237 However, if the appointment on 20 July was missed because of Child LK being unwilling or unable to attend, one might also expect to see documentation of an attempt to rebook (as occurred on 18 July).[208]

238 There is no such evidence.

239 Ultimately, I consider both inferences are open and in the absence of further evidence I am unable to find one as being more likely than the other.

240 As such, I make no finding as to why Child LK did not attend the 20 July 2023.

241 What is clear from the evidence is that Ms McKnight emailed Lifestyle Solutions about the non-attendance, seeking some clarity as to why the appointment was missed, and that she received no response.[209]

242 I find that Lifestyle Solutions' staff failed to respond to Ms McKnight's enquiries about the missed appointment in a prompt way, and that, at least in part, delayed her ability to organise a new appointment from Child LK with CAMHS.

243 I do not consider that such delay had any bearing on the events of 23 August 2023.

[205] Exhibit 1, tab 19, p 347.
[206] Exhibit 2, tab 1, par [4.4].
[207] Ts 70-71.
[208] Ts 60.
[209] Exhibit 1, tab 22.1, par [76].

244 At most, it delayed an ability for CAMHS to further assess Child LK, and for the Departmental staff to put together a brief to a private practitioner for ongoing therapy.[210]

Further appointment with Dr Cresp on 7 August 2023

245 Child LK's further appointment with Dr Cresp on 7 August 2023 was, self-evidently, an important one – both for the purposes of reviewing the progress of her treatment plan, but also to solidify the positive therapeutic relationship between Child LK and Dr Cresp.

246 Ms McKnight is not able to recall any information about why Child LK did not attend the appointment.[211]

247 A question arises on the available evidence as to whether Lifestyle Solutions were made aware of the further appointment – by the Department, as should have occurred, or by any other means.

Did the Department inform Lifestyle Solutions of the appointment?

248 On 11 July 2023, Ms McKnight received a letter from WACHS advising that Child LK had a paediatric appointment booked for 7 August 2023.[212]

249 The letter, dated 7 July, was addressed to the Department and is stamped by the Department as having been received.[213]

250 There is no record that indicates a copy of the letter was sent to Lifestyle Solutions.[214]

251 In her supplementary statement, in direct response to a query from the Court,[215] Ms McKnight confirmed that there are no available records of steps taken to communicate the appointment to Lifestyle Solutions.[216]

252 Mr Mace confirmed the same at the inquest.[217]

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[210] Ts 78.
[211] Exhibit 1, tab 22.1, par [80].
[212] Exhibit 1, tab 22.1, par [73].
[213] Exhibit 1, tab 25.
[214] Ts 73.
[215] Exhibit 1, tab 22.3.
[216] Exhibit 1, tab 22.2, par [13].
[217] Ts 73.

253 Mr Branson notes that a search of Lifestyle Solutions' records has not identified any record of communications from the Department to Lifestyle Solutions confirming Child LK's appointment with Dr Cresp on 26 June 2023, or the follow up appointment on 7 August 2023.[218]

254 In the absence of any witness with an independent recollection, there are two inferences open on the documentary record before the Court as to Ms McKnight's communication of the 7 August follow-up appointment.

255 One inference is that Ms McKnight communicated the fact of the follow-up appointment to Lifestyle Solutions, and the communication was not recorded (either because it occurred by way of telephone call, for example, or any written record of the communication has not been retained).

256 The second inference is that Ms McKnight overlooked communicating the fact of the follow up appointment to Lifestyle Solutions.

257 The first inference is supported by matters including:

(a) Ms McKnight's evidence that the case file is not representative of all communications that occurred,[219] such that the absence of a documentary record does not axiomatically mean that the fact of the appointment was not communicated;

(b) Ms Vergara Belmar attended the 26 June 2023 appointment with Child LK, thus it can be inferred that Lifestyle Solutions was advised by Ms McKnight of that first appointment, even though there is, now, no written record of this having occurred;

(c) Ms McKnight's evidence that although she tried to use email where possible, her practice was not always to email Lifestyle Solutions to confirm the booking of a specialist appointment;[220]

(d) Ms McKnight's evidence that before taking parental leave, she placed handwritten notes into a secure destruction bin, and in doing so, may have inadvertently disposed of any handwritten note of any call advising of the booking of the specialist appointment;[221] and

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[218] Exhibit 2, tab 1, par [9.3]; ts 66.
[219] Submission of Ms McKnight filed 19 December 2025, pars [21].
[220] Submission of Ms McKnight filed 19 December 2025, pars [7]-[8].
[221] Submission of Ms McKnight filed 19 December 2025, pars [11]-[12].

(e) Child LK often refused to attend appointments, such that it is feasible that the fact of the appointment was communicated, but not recorded by either the Department or Lifestyle Solutions, and Child LK simply refused to attend.

258 The second inference is supported by matters including (in addition to neither the Department nor Lifestyle Solutions having any record):

(a) the evidence at the inquest that the dates for paediatric appointments were generally communicated by the Department to the Therapeutic Support Manager at Lifestyle Solutions by email, not by phone;[222]

(b) the absence of any evidence that Ms McKnight sought to remind Lifestyle Solutions of the follow-up appointment, which was her ordinary practice at the time,[223] and which she did in relation to the previous appointment with CAMHS (see par [78] above);

(c) the absence of any record of Ms McKnight sending a Microsoft Teams meeting invitation regarding the 7 August appointment to Lifestyle Solutions, something she did in relation to the CAMHS appointment;[224]

(d) the fact that Ms McKnight was managing 15 cases at the relevant time,[225] while working part-time;[226] and

(e) the fact that Ms McKnight was otherwise working within a Departmental region which was understaffed.[227]

259 In relation to (c) above, Ms McKnight's evidence is that it was not her general practice to use calendar invitations to confirm booking of specialist appointments, given the fact it may inadvertently exclude staff at an organisation like Lifestyle Solutions.[228]

260 I accept that evidence (including due to the cogent logic behind it), and place less weight on the matter at (c) above, accordingly.

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[222] Ts 49; 60.
[223] Exhibit 1, tab 22.2, par [12(a)].
[224] Exhibit 2, tab 2, entry for 3 July 2023.
[225] Exhibit 1, tab 22, par [17].
[226] Exhibit 1, tab 22, par [12]. See also the matters identified by Ms McKnight in her submission filed 19 December 2025, at pars [23(a)-(f)].
[227] Ts 80.
[228] Submission of Ms McKnight filed 19 December 2025, pars [17]-[18].

261 Again, the matter is finely weighed, and having regard to all the available evidence, I am unable to determine to the requisite standard that one of the two inferences is more likely than the other.

262 In those circumstances, I make no finding as to whether the Department communicated the fact of the 7 August appointment to Lifestyle Solutions.

Was Lifestyle Solutions aware of the appointment, otherwise?

263 In preparation for the inquest, Lifestyle Solutions identified an internal email sent from its Albany Service Outlet to then Therapeutic Service Manager, linking to the discharge summary from Child LK's hospital admission on 29 July 2023.

264 The discharge summary included a reference to the upcoming paediatric appointment on 7 August.[229]

265 There is no evidence that this information, within the discharge summary, was identified by any staff at Lifestyle Solutions who received the email, or actioned (including by seeking clarification from the Department about whether such an appointment had been scheduled).

266 There is otherwise no evidence of any staff at Lifestyle Solutions being independently aware of the upcoming appointment for 7 August 2023.

Should the need for a further review have been apparent, notwithstanding?

267 I find that:

(a) the Department had been notified by WACHS of the further appointment with Dr Cresp;

(b) Lifestyle Solutions was in possession of at least one important document concerning Child LK's healthcare which, if examined carefully, would have alerted staff to the upcoming appointment; and

(c) there is otherwise insufficient evidence to enable a finding as to why Child LK did not attend the appointment on 7 August 2023.

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[229] Exhibit 3.

268 During submissions, counsel for Lifestyle Solutions candidly and appropriately recognised that, putting aside the issue of whether Lifestyle Solutions had been notified of the appointment, there was an awareness that Dr Cresp's treatment plan involved a review after six weeks.[230]

269 It is clear that Dr Cresp communicated the need for follow up in about six weeks, to both Ms Vergara Belmar (at the appointment)[231] and Ms McKnight (both in their verbal conversation shortly after the appointment[232] and by the letter to the GP).[233] Other staff at Lifestyle Solutions were also aware of the plan for a review after six weeks.[234]

270 The follow up appointment had been scheduled on 7 August, being the date six weeks after the initial consultation.

271 It is not apparent that anyone involved in Child LK's care, within the Department or Lifestyle Solutions, recognised, between 7 and 23 August 2023, that there had not been a review by Dr Cresp.

272 I accept, as submitted by counsel for Lifestyle Solutions, that the six-week period was a 'loose figure',[235] but it had been over eight weeks since the initial consultation when Child LK died.

273 I find that the need for a review being overlooked by the Department and Lifestyle Solutions was a consequence of:

(a) one of the people most involved in Child LK's day-to-day care, Ms Vergara Belmar, being on leave from work unexpectedly;[236] and

(b) Ms McKnight's intense workload, in the context of other personal circumstances she was managing at the relevant time.[237]

274 Self-evidently, sufficient systems should be in place so that the absence, unavailability, or diversion of individuals involved in the day-to-day care of a child in Departmental care does not result in such a need being overlooked entirely.

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[230] Ts 87.
[231] Ts 25.
[232] Ts 25.
[233] Ts 26.
[234] Ts 64-65.
[235] Ts 87.
[236] Ts 48.
[237] Submission of Ms McKnight filed 19 December 2025, pars [14], [23].

275 I return to the improvements made by both the Department and Lifestyle Solutions in this regard below.

Consequence of the appointment not occurring

276 While it was regrettable that Child LK did not attend the follow-up appointment, and that the plan for review after six weeks was overlooked by the Department and Lifestyle Solutions prior to his death, there is no basis to conclude that either matter was contributory to the tragic outcome on 23 August.

277 At the inquest, Dr Cresp said that she was 'half expecting' Child LK not to attend the appointment, given his known aversion to attending medical appointments previously.[238]

278 At the further appointment, Dr Cresp said she would have inquired into any seizure activity, and how Child LK had been going on the medication. She would have also looked at the blood tests to see if there had been any change in his platelets or liver function, and in the absence of any issues, potentially titrating the dose upwards if necessary.

279 Dr Cresp noted that at the six-week mark, Child LK would only have been on the therapeutic dose for about a week, so it is difficult to say what, if anything, might have occurred in relation to medication at such a review.[239]

280 According to Dr Cresp, there would have been no indication on 9 August that Child LK was going to die shortly about two weeks later.[240] I accept her evidence in that regard. I also accept her evidence that increasing the medication dose would not have ameliorated the increased risk of seizure caused by any concurrent infections.[241]

281 Although Dr Cresp was mindful of Child LK's ongoing risk, by rebooking a further appointment in four to six weeks it was clear that Dr Cresp did not consider that Child LK's failure to attend on 7 August (or have a review of his medication on that date) gave rise to such a critical or imminent risk that immediate action by the Department or Child LK's carers was required.

[238] Ts 27.
[239] Ts 27.
[240] Ts 27.
[241] Ts 34.

Improvements since Child LK's death

282 There was ample evidence at the inquest that WACHS, Communities and Lifestyle Solutions have all been working (including collaboratively) toward improving communications surrounding medical appointments and attendance.

283 Dr Cresp referred to the Integrated Paediatric Service constantly reviewing to try and understand why patients may not attend, and what systems might be put in place to help support families to attend.[242]

284 Dr Cresp referred to specific examples including the introduction of a clinic nurse manager role, and a non-attendance pathway (including involvement by social workers) for patients deemed high risk who have missed two appointments.[243]

285 Dr Cresp also referred to the Service identifying a higher non-attendance from children in care than children not in care, and as a consequence, for the past couple of years, meeting with the Department and identifying ways in which that can be addressed and improved (including by centralising avenues of communications).[244]

286 Mr Mace confirmed the existence of a detailed bilateral agreement between WACHS and the Department which descends to built-in escalation pathways, and systemic issue identification.[245] WACHS referred to the same in a separate submission to the Court.[246]

287 Mr Mace's view was that the agreement, and the ongoing collaboration between the Department and WACHS has been constructive.[247] I commend both agencies for their collaborative focus, and encourage their continued adherence to the approach.

288 At the inquest, Mr Branson explained that Lifestyle Solutions now employs allocated caseworkers, and his expectation is that, as at today, a caseworker would have reviewed a document like the 29 July discharge summary and become alive to the upcoming appointment.[248]

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[242] Ts 31.
[243] Ts 31.
[244] Ts 32.
[245] Ts 74.
[246] Exhibit 1, tab 24.
[247] Ts 74.
[248] Ts 65.

289 I accept this evidence, and find that this is a helpful check mechanism, noting that Lifestyle Solutions is not directly responsible for the scheduling of paediatric appointments for children in care.

290 Lifestyle Solutions is also employing an electronic client management system (Carelink) and calendar, viewable by case manager and live-in carers,[249] which I find will decrease any risk of appointments for children living at Pegasus being potentially overlooked.

291 I also note that Lifestyle Solutions has implemented a measure identified in its internal review, namely ensure that any refusal of medical treatment is documented with supporting evidence.[250]

292 I find that this will ensure greater clarity in future cases as to why appointments may have been missed by children in care.

Communication between the Department and Lifestyle Solutions

293 The evidence in the coronial brief raised an issue, aside from the missed medical appointments, as to whether the division of responsibilities between the Department and Lifestyle was clearly understood by staff, and applied uniformly.

294 Also, as with many cases before this Court, there was evidence that communication between Lifestyle Solutions and Departmental staff in relation to Child LK's care and supervision may have been suboptimal at times, at least in terms of the responsiveness by Lifestyle Solutions staff to Ms McKnight's inquiries in late July and early August 2023.

295 As identified above, Mr Branson accepts that staffing levels were an issue for Lifestyle Solutions at the relevant time.

296 However, there is evidence that in the second half of 2023, a Service Specialist at Lifestyle Solutions led an intensive recruitment drive to strengthen the care teams in Western.[251]

297 Mr Branson also gave evidence at the inquest that Lifestyle Solutions has reduced the amount of agency staff from 23 per cent to 9 per cent in the course of 2025.[252]

[249] Ts 65-66.
[250] Exhibit 2, tab 1, par 13.2; ts 67.
[251] Exhibit 2, tab 1, par [3.20].
[252] Ts 68.

298 I find that this concentration on the reduction of agency staff, including by creating a relief program which calls on existing, trained staff, [253] will improve communication between Departmental and Lifestyle Solutions staff.

299 Mr Mace gave evidence that the Department, correspondingly, has implemented initiatives to increase staffing levels in regions including the Great Southern, and that there has been a significant reduction in vacancies within the district, including at senior levels.[254]

300 As alluded to earlier in these findings, Lifestyle Solutions has undergone an operational redesign, with the express goal to align its management structure with the Department's – such that a Lifestyle Solutions' caseworker allocated to a child under their supervision will be able to work directly with the Departmental case worker.[255]

301 While it is was clear at the inquest that Mr Branson and Mr Mace held the same views about who was responsible for procedural aspects of certain healthcare-related matters for children like Child LK in group home settings,[256] I anticipate that Lifestyle Solutions' operational redesign will, as was intended:[257]

(a) avoid any confusion between staff of the agencies as to their respective responsibilities (something which the Department's internal review identified as a possible contributing factor to the absence of case management by Departmental staff in Child LK's case at times[258]); and

(b) relatedly, avoid any potential overreliance by the Department on an agency like Lifestyle Solutions (as the Departmental review identified may have occurred in Child LK's case).[259]

[253] Ts 68.
[254] Ts 80.
[255] Ts 61.
[256] Exhibit 2, tab 1, pars [3.28], [4.13]; ts 62-63, 73.
[257] Ts 69.
[258] Exhibit 1, tab 15, p 11.
[259] Exhibit 1, tab 15, p 12.

302 I also accept that Lifestyle Solutions' introduction of therapeutic specialists (who can attend appointments with children) will decrease the burden on live-in carers,[260] and permit greater responsiveness to Departmental queries.

303 Similarly, I accept that Lifestyle Solutions' appointment of their former Chief of Staff to a position which leads work to identify and address gaps in Lifestyle Solutions' compliance with its contract with the Department[261] will result in improved communication.

Referral to YPECN

304 The final issue addressed by evidence at the inquest was Child LK not being referred to the YPECN program, despite that being recognised as a potential course in April 2023.

305 I had cause to question the decision to pause any referral to such a 'wrap-around' service pending the CAMHS assessment, given:

(a) there had been ten changes in the Departments' allocated case manager for Child LK during the timeframe considered by the internal review, ranging from 31 days to 9 months;[262]

(b) Departmental quarterly reports were six months overdue,[263] and (as identified above) health reviews were also overdue;

(c) despite his enthusiasm for Alta-1, Child LK's progress towards readiness for full-time schooling had been slow, and behavioural challenges had prevented a transition to Alta-1's middle school program;[264] and

(d) though there had been a reduction in risky behaviours by Child LK, it was clear that the risks to his psychical and mental health were ongoing and unlikely to be capable of resolution through the upcoming CAMHS consultation (including because that service would be unable to provide long-term psychotherapy which Child LK clearly required).[265]

[260] Ts 62.
[261] Exhibit 2, tab 1, par [13.18].
[262] Exhibit 1, tab 15, p 10.
[263] Exhibit 1, tab 15, p 12.
[264] Exhibit 2, tab 1, par [4.17].
[265] Exhibit 1, tab 16; ts 24-25.

306 Notwithstanding the above, Mr Mace's unambiguous evidence was that even if a referral had been made, Child LK would not have met the threshold criteria for acceptance into the program.

307 Mr Mace's evidence was that the YPECN program had 24 spaces, which were occupied by the most complicated children in the Department's care – such children often dealing with chronic substance misuse issues, cycling through juvenile detention, and/or engaging in incredibly self-destructive behaviours.[266]

308 I accept Mr Mace's evidence about the prospect of Child LK being admitted to the program had a referral been made, based not just on his experience in child protection work, but because he was the Chair of the YPECN program at the relevant time.[267]

309 Mr Mace's view is reinforced by Ms Vergara Belmar's evidence that Child LK was not the most challenging case she saw in her seven-year career with Lifestyle Solutions.[268]

Conclusions

310 As would be expected, it is clear that the agencies and staff involved in the care and supervision of Child LK have reflected carefully on what lessons can be taken from his unfortunate death, and what improvements can be made.

311 I reiterate the observation that to the extent there were any matters missed or overlooked in the course of Child LK's care by the Department or by Lifestyle Solutions, they did not contribute to his death.

312 As I observed at the end of the inquest, the outcome of this case was perverse – Child LK died unexpectedly at a time when he appeared to have settled in his placement with Lifestyle Solutions, had formed a strong bond with Ms Vergara Belmar, had an active Departmental caseworker in Ms McKnight, and had a well-considered treatment plan in place following consultation with Dr Cresp.

[266] Ts 76.
[267] Ts 74.
[268] Ts 51-52.

313 Child LK's death at such an early age was and is heartbreaking, but his family, his friends, and the community at large, can be reassured that there were many people and organisations dedicated to his care, and who continue to strive to improve their service to some of our most vulnerable.

BD Nelson
Coroner
22 December 2025