CITATION: *Inquest into the death of Debbie Anne Douglas* [2005] NTMC 009

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0124/2004
DELIVERED ON:	1 March 2005
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HEARING DATE(s):	1 March 2005
FINDING OF:	Mr G Cavanagh

CATCHWORDS:

Death of a Child in Care
Coroners Act 1993 (NT) S12(1)(a), s15(1)(a)

REPRESENTATION:

Counsel:

Assisting:	Ms Brenda Monaghan

Judgment category classification:	A
Judgement ID number:	[2005] NTMC 009
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0124/2004

In the matter of an Inquest into the death of

DEBBIE ANNE DOUGLAS
ON 23 JULY 2004
AT ROYAL DARWIN HOSPITAL

FINDINGS

(Delivered 1 March 2005)

Mr GREG CAVANAGH:

1. Debbie Anne Douglas ("the deceased") died at Royal Darwin Hospital on 23 July 2004.

2. Section 12(1) (a) of the *Coroners Act* ("the Act") defines a "reportable death" to include a death:

> (vii) of a person who, immediately before death, was a person held in care or custody:"

3. At the time of his death, the deceased was held in "care" as defined in s12(1)(a) of the Act. Consequently this Inquest was mandatory as required by s15(1)(a) of the Act

4. Section 34(1) of the Act details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

> "(1) A coroner investigating -
>
> (a) a death shall, if possible, find -
>
> (i) the identity of the deceased person;

(ii) the time and place of death;

(ii) the cause of death;

(iii) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

(iv) any relevant circumstances concerning the death."

5. Section 34(2) of the Act operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

6. The evidence tendered at the Inquest enables me to make the following formal findings as required by the Coroner's Act.

FORMAL FINDINGS

(a) The identity of the deceased was Debbie Anne Douglas, an Aboriginal female born on 19 April 2001 at Katherine Hospital Northern Territory.

(b) The time and place of death was on 23 July 2004 at 2315 hours in Ward 5B Royal Darwin Hospital, Darwin NT

(c) The cause of death was complications resulting from progressive right ventricular failure as a consequence of her congenital heart disease.

(d) The particulars required to register the death are:

1. The deceased was a female.

2. The deceased was of Aboriginal Australian origin.

3. The death was reported to the Coroner.

4. The cause of death was confirmed by post-mortem examination.

5. The death was caused in the matter described in paragraph (c) above.

6. The pathologist viewed the body after death.

7. The pathologist was Dr Terence John Sinton of Royal Darwin Hospital.

8. The father of the deceased is Ronald Douglas born 13 July 1966 and the mother of the deceased is Daphne Echo born 17 August 1972.

9. The usual address of the deceased was 1 Cox Crescent, Katherine, Northern Territory of Australia.

THE DECEASED

History

7. Debbie Anne Douglas died at Royal Darwin Hospital on 23 July 2004. At the time of her death, the child was held in "care" -consequently this Inquest is mandatory as required by s15(1)(a) of the Coroners Act. The deceased was much loved by her parents, extended family and carers.

8. Senior Constable Heath Eaves conducted a coronial investigation into the death of this child and I commend him for his thoroughness.

9. During the Inquest, evidence was given by Dr Charles Kilburn, Paediatrician, Royal Darwin Hospital. He was the only witness called. Also tendered were statements from Judith Heyes (the child's foster mother), Alexis Jackson (manager of Family and Childrens Services ["FACS"] at Katherine), the medical files from Royal Darwin Hospital, Katherine District Hospital and the Kintore Clinic, as well as the investigation brief.

This evidence has enabled me to retrace the history of this child and reach certain conclusions as regards the circumstances of her death.

10. The deceased was born in Katherine on the 19 April 2001 with Di George syndrome. Senior paediatrician from Royal Darwin Hospital, Doctor Kilburn gave evidence that this syndrome is characterised by specific cardiac malformations, a subset of facial attributes and certain endocrine and immune anomalies. In Debbie Anne's case, she was developmentally delayed and suffered from serious congenital heart problems. She also had quite marked immune system and feeding problems as features of this syndrome.

11. For the first two years of her life, Debbie Anne lived at Yanula Camp, Borroloola with her parents. Her mother Daphne Echo and her father Ronald Douglas (who is here today) had for some time prior to her death struggled with serious alcohol problems and domestic violence. It was difficult for them to properly care for a seriously ill child who had spent a considerable amount of time in hospital both in the Territory and interstate as a result of her medical condition.

12. Katherine FACS first became involved with the child's care in September 2002 when she was some 17 months of age regarding concerns that Debbie Anne's parents were unable to properly care for her medical needs. At this stage she was not removed from her family but FACS attempted to support extended family members to care for the child.

13. Debbie Anne was taken into care by Katherine FACS on 29 August 2003 when she was two years four months of age as she urgently needed medical treatment interstate for a cardiac catheterisation and major heart surgery. The Health Department files show that her medical condition was becoming critical and no family members were willing or able to accompany her. The child remained in care until her death.

14. In September and October 2003, the child underwent surgery in Adelaide and Melbourne. She returned to Katherine in December 2003 and was placed with Judith Heyes, a departmental foster carer with whom she principally resided from that time on. There is no issue with the fact that Debbie Anne was well cared for by her foster mother and other carers despite her often fragile health.

15. On 28 and 29 June 2004, Judith Heyes noticed that Debbie Anne had developed a small cough. On 30 June, she took the child to a scheduled appointment with specialist paediatric cardiologist Dr Wheaton at Katherine Hospital. Ms Heyes told the specialist about Debbie Anne's cough and a cardiogram and ECT were taken.

16. On 1 July, Ms Heyes took Debbie Anne to her GP Dr King because she was concerned that the child hadn't eaten breakfast and was lethargic. Dr King told Ms Heyes to ensure that the child continued to take liquids and he prescribed amoxil. The following morning on 2 July, Debbie Anne was very lethargic and she refused her medication. Dr King again examined her and then arranged for her admission to Katherine Hospital. Later that day, Debbie was flown to Royal Darwin Hospital and was placed in intensive care. It soon became apparent that Debbie Anne's heart condition had become very serious and that she had very little chance of recovery. During this period, Debbie Anne's mother spent time with her in RDH and her father- who at the time was in Berrimah Correction Facility- had regular supervised contact with her.

17. On or about 21 July 2004 after consultation with Debbie Anne's parents and senior FACS management, Alexis Jackson on behalf of the Department consented for Debbie Anne to receive no further medical treatment to prolong her life, other than medication to ease any pain and make her comfortable. This decision was made as the child's organs continued to fail

and FACS were advised by senior medical staff that further surgery was no longer an option. Debbie Anne died 2 days later.

18. I find that the deceased received a good standard of care from her foster carer, her general practitioner, Family and Children's Services in Katherine, Katherine District Hospital and Royal Darwin Hospital. She died of complications resulting from progressive right ventricular failure as a consequence of her congenital heart disease. Consequently, I have no recommendations to make or other comments in relation to this death.

Dated this 1st day of March 2005.

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GREG CAVANAGH
TERRITORY CORONER