CITATION: *Inquest into the death of Baby C* [2014] NTMC 017

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0002/2013
DELIVERED ON:	1 September 2014
DELIVERED AT:	Alice Springs
HEARING DATE(s):	22 to 24 July, 2014
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death of baby in care of foster parent; cause of death undetermined; care and treatment whilst at hospital and in care.**

REPRESENTATION:

Counsel Assisting:	Mr Mark Thomas
Department of Health:	Dr Peggy Dwyer
Department of Children And Families:	Mr Simon Lee

Judgment category classification:	A
Judgement ID number:	[2014] NTMC 017
Number of paragraphs:	78
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A suppression order was issued by the Coroner. The name of the Deceased and anything that might identify her name is suppressed.

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE
NORTHERN TERRITORY OF
AUSTRALIA
No. A0002/2013

In the matter of an Inquest into the death of

BABY C
ON 9 JANUARY 2013
AT 5A HONG ST, GILLEN ALICE SPRINGS

FINDINGS

Mr Greg Cavanagh SM:

INTRODUCTION

1. Baby C was born on 1 July 2012 at Alice Springs Hospital eight weeks premature after a gestation period of 32 weeks. She was a small baby, weighing 1.64kgs at birth and 40.5cm in length. She remained in Alice Springs Hospital until her discharge on 21 August 2012. She was then released into the care of her parents Ms D and Mr N. Subsequent to her discharge from hospital her life was relatively uneventful until the early hours of 1 January 2013.

2. At about 3am on 1 January 2013, security staff at Lasseters Casino in Alice Springs were alerted to the presence of a baby and a toddler in an unattended motor vehicle that was parked in the car-park[1]. The children were alone. Security staff checked the children. The baby, who was later identified to be Baby C, was asleep and appeared to security staff to be unresponsive to touch. The security staff called police who arrived a short time later. Just prior to police arrival the parents of the children arrived at

[1] Uncertified data from the Bureau of Meteorology indicated that the temperature in Alice Springs was between midnight and 3am was between a high of 24 degrees and a low of 21.7 degrees.

the scene. Both were affected by alcohol and the female accused her partner of assaulting her. One of the security staff observed the mother of the children, Ms D, to shake the baby like a rag doll, hard enough for the baby's head to flop backwards and forwards. She did this three or four times. The baby opened her eyes but they were quite glazy according to Mr Usher, one of the security personnel. Police arrived after a short period of time and a little later an ambulance arrived to take the baby away to the Alice Springs Hospital. The parents did not accompany Baby C to hospital.

3. Medical staff thoroughly examined Baby C at Alice Springs Hospital. This examination revealed that she had sustained no physical injuries. She was able to consume formula milk from a bottle on a regular basis and was alert and able to interact with others. Other than the symptoms of an incipient head cold she was in a reasonable physical condition. The head of the paediatric medical staff determined that Baby C was fit to be discharged from the hospital on 2 January 2013.

4. However, as a consequence, in part, of the events of the early hours of 1 January 2013, Baby C was not discharged into the care of her parents. The reason for this was that a provisional protection order had been obtained by the Department of Children and Families (hereafter DCF) on 1 January 2013 pursuant to s 51 of the Care and Protection of Children Act 2007. This order operated for 72 hours. On 3 January, the DCF applied to the Local Court in Alice Springs for a Temporary Protection Order under s104 of the aforementioned Act. On 3 January, the Court granted a Temporary Protection Order for Baby C giving daily care and control of her to the CEO of the DCF for 14 days. DCF decided that Baby C was to be placed into the hands of a foster carer on a temporary basis. The foster carer selected for this role was Ms Ronda Preston, aged at that point 81 years[2], an Alice Springs resident with, at that time, 52 years of experience as a foster carer of children in care, of which about 16 years had been in the Northern

[2] Date of birth: 12 January 1931.

Territory, and, who had in recent years focused upon the care of young babies. Ms Preston resided at a two-bedroom unit at 5A Hong St, in the suburb of Gillen in Alice Springs.

5. A DCF employee named Mr Derebail Rao arrived at Ms Preston's home[3] on 2 January 2013 and handed over Baby C to her. From that point, until her death, Baby C remained in the care of Ms Preston.

6. Ms Preston and Baby C were visited by a number of persons over the next few days, some of whom observed, in general terms, that the baby did not look well. Ms Preston said to a number of people that the baby's bowels were not working. Further, she said that Baby C had no regular sleep pattern and that she had to be force fed from a bottle. Ms Preston was aware that up until the point that Baby C had been received at Alice Springs Hospital on 1 January, that she had been breast fed.

7. At a point that is impossible to determine with precision, Baby C's health declined significantly and on 8 January 2013 she was observed by at least one other visitor to the house to not be looking well on that day.

8. At about 1am on 9 January 2013 Ms Preston checked on Baby C who was in her regular location, which was her bassinette in the dining room of Ms Preston's home. Baby C was alive at this point and under a ceiling fan that was operating above her.

9. At about 7am on 9 January 2013, Ms Preston awoke from what she believed to be a deep sleep. The house was quiet. She checked quickly on the baby in the bassinette and detected no sound. She showered and returned a short time later and saw Baby C with her head slightly on her side with her eyes and mouth open. Baby C was entirely still and Ms Preston formed the view that she had died. Ms Preston remained fixed on the spot for a significant period of time, perhaps an hour, before telephoning her daughter in Darwin.

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[3] A single story double bedroom unit at 5A Hong St, Alice Springs.

Her daughter in turn alerted the authorities. Shortly thereafter, Ambulance staff arrived at the premises. At 8.32am St John's Ambulance officer Tom Falzon determined that Baby C was dead. Baby C was six months and eight days old.

10. On 11 January 2013 Baby C was the subject of an autopsy. The Forensic Pathologist who conducted the autopsy, Dr Terence Sinton, examined the body of Baby C and determined that the cause of death was chronic malnutrition. It is important to note that the word "chronic" has a precise medical definition, which refers to the persistence for a lengthy period of time or constantly recurrence of a medical problem. It is commonly contrasted with an "acute" medical problem. Hence, Dr Sinton was of the view, at the time that he conducted the autopsy, that Baby C had suffered, in effect, longstanding malnutrition that was the direct cause of her death. This opinion was subsequently re-appraised by Dr Sinton and analysed by a specialist paediatrician who gave evidence in this Inquest. The specialist, Dr Rose Fahy, was of the opinion that chronic malnutrition was not the cause of the death of Baby C and postulated two other causes. For reasons that will be examined in detail in these findings, it is not possible to determine the precise cause of death of Baby C.

11. Mr Mark Thomas appeared at the Inquest as Counsel Assisting. Dr Peggy Dwyer appeared for the NT Department of Health. Mr Simon Lee appeared for the NT DCF. Mr Ben Mason of the Central Australian Aboriginal Legal Service did not appear at the bar table but had what might be described as being a watching brief in the matter. Both parents attended each day of the three day Inquest.

12. I received into evidence the investigation brief prepared by Detective acting Senior Sergeant Tony Henrys, which comprised, in essence, the key materials in this matter. In addition, a bundle of other materials were tendered, which included the medical records of Baby C and her mother, the

DCF files of the parents and Baby C, the birth certificate of Baby C, and the statement of Dr Fahy (which was obtained subsequent to the investigation brief being compiled).

13. Detective acting Senior Sgt Henrys gave evidence at the Inquest as did Chris Usher, Anthony Blansjaar, Derebail Rao, Gabby Brown, Ms Christine Kleingeld, Kate Lewis, Ms Ronda Preston, Jennifer Holme, Trevor O'Neill, Tom Falzon, Dr Catherine O'Connor, Dr Terence Sinton, Dr Rose Fahy, Constable Amanda Hardy and Constable Jason Macheacek. At the end of the Inquest, Counsel Assisting spoke to the mother of Baby C, Ms D, and drew to my attention via a handwritten statement, Ms D's view of the matter. I should add at this point that I extend to her and to Mr N my sympathy for their tragic loss.

14. Pursuant to section 34 of the Coroner's Act (hereafter "the Act"), I am required to make the following findings:

(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;

(iii) The cause of death;

(iv) The particulars needed to register the death under the Births, Deaths and Marriages Registration Act.

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

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

16. Furthermore, I may make recommendations pursuant to section 35 (1), (2) and (3):

> "(1) A Coroner may report to the Attorney-General on a death or disaster investigated by the Coroner.
>
> (2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.
>
> (3) A Coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner."

Reported When and by Whom

17. St Johns Ambulance officer Tom Falzon determined Baby C as being deceased at 8.32am, which was one minute after he attended Ms Preston's home at 8.31am on 9 January 2013.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

Medical Background of Baby C

18. Baby C died at the age of six months and eight days. She was the ninth child of her mother Ms D and the second child born to the union of Ms D and her father Mr N. The other product of this union, Baby C's then two-year-old brother Baby K, was also taken into foster care at about the same time as Baby C.

19. In addition to the attenuated summary of Baby C's medical history outlined above in the Introduction to these Findings it is useful to state, in tabular form, the following key data applicable, where available, to Baby C's life:

DATE	HEIGHT	WEIGHT	HEAD CIRCUM.[4]
BIRTH 1 July 2012	40.5cm	1.64kg	30cm
DISCHARGE 21 August 2012	47cm	2.6kg	35cm
Attendance at hospital on 13 Sept 2012 (Dr Duc)	49cm	3.06kg	36.1cm
Attendance at hospital on 17 Oct 2012	52.5cm	3.73kg	37cm
Discharge from Hospital on 2 Jan 2013	Stated as 65cm (which is an error)	4.79kg on discharge. (4.91kgs on admission) (note: not specified if splint worn at weighing)	39.5cm

[4] Circumference

DEATH	59cm[5]	4.01kg[6]	39cm

20. Baby C's birth weight of 1.64 kg was, as Dr Fahy observed, between the 10th and 50th percentile for that gestation. Baby C's length of 40.5cm placed at her at the 10th percentile for that gestation. Baby C's head circumference of 30cm at birth placed her on the 50th percentile for that gestation period. It ought to be noted that the percentile reading is a relative term that refers to the percentage of the population of the same age and gender that falls below that percentile. For example, the 10th percentile means that 10% of the female population of the same age recorded readings of less than the reading recorded by Baby C. On the other hand 90% of the female population of the same age would register a reading greater than Baby C.

21. A further crucial matter with regard to medical terminology is that it also must be understood that a "corrected" age is used by paediatricians when plotting growth charts for premature babies in relation to the three key parameters that are used in measuring growth: body length, weight and head circumference. The "corrected" age is arrived at by simply deducting the period of prematurity from the biological age of the baby. For example, a baby of four months biological or calendar age, who was born two months premature, has a "corrected" age of two months.

22. Baby C was active at birth and required minimal resuscitation. Dr Fahy noted that Baby C had mild respiratory distress that required support for 24 hours. She also received antibiotics for 48 hours pending laboratory results as well as intravenous (IV) fluids for her first 24 hours. Dr Fahy noted these procedures are very common for infants of Baby C's gestation and size. She

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[5] This was initially recorded in the autopsy report compiled by Dr Sinton as being 51 cm, which he subsequently stated to be a typographical error.

[6] This weight recording was obtained at the autopsy, which was conducted two days after her death and assumes that there was no meaningful difference between the weight at death and at the autopsy.

initially started on nasogastric feeds of expressed breast milk on day two before shortly transferring to full breast milk.

23. While an in-patient in the Special Care nursery, Baby C was observed to have a systolic murmur of approximately 2/6 at the upper level sternal edge. The rest of her cardiovascular examination was unremarkable. She had an echocardiogram performed on 16 August 2012, which showed very mildly increased velocities in the left pulmonary artery but with normal left atrial and left ventricular function. The electrocardiogram was reviewed by a paediatric cardiologist, Dr Wheaton, who was of the opinion that it was the normal study of an infant.

24. Regarding medication, there is no record of any medication routine other than supplements to assist with good health and development.

25. On discharge from hospital on 21 August 2012 Baby C's parents had ongoing support in place from a number of social agencies that included the Central Australian Aboriginal Congress, the Targeted Family Support Service as well as Anglicare.

26. On 13 September Baby C attended the paediatric unit of Alice Springs Hospital for an outpatient review. Dr Jacqueline Duc conducted a thorough review, which identified no pressing issues of concern save for a problem with her hip, which was to be subjected to ultrasound and correction.

27. On 17 October Baby C attended the outpatient clinic at the Alice Springs Hospital. An ultrasound was conducted. Her weight at this biological age of three and a half months (corrected age of six weeks) was 3.73kg. This was between the third and 15th percentiles when adjusted for her corrected age. Her length was 52cm, which was just below the 15th percentile. Her head circumference was recorded by Dr Fahy as being at the 50th percentile point.

28. The ultrasound test performed upon Baby C's hip showed developmental dysplasia[7] of the left hip, which was probably, (according to Dr Fahy), related to the breech positioning in utero. On 18 October a splint was applied to Baby C's hip for the purpose of keeping the hip joint in the correct position while the ball and socket joint developed. Physiotherapists reviewed this on 25 and 26 October.

29. Baby C was seen in the hospital's emergency department on 6 December where she presented with a cough. All examinations were normal. She was observed for two and a half hours and then discharged.

30. Dr Fahy plotted Baby C's growth in relation to the three key parameters of height, weight and head circumference on charts in which she used the corrected age of Baby C that allowed for her premature birth. Regarding weight, Dr Fahy opined[8] that there appeared to be some flattening of growth in that Baby C was just above the third percentile at six weeks (corrected age) and to just below the third percentile at four months (corrected age) on 1 January 2013. Regarding body length Dr Fahy, regrettably, received inaccurate data pertaining to both the discharge date on 2 January as well as the length at death. However, the corrected data, which contains the length at death of 59cm, demonstrates that Baby C did continue to grow in length, albeit between the third and 15th percentile. Regarding head circumference Baby C grew and tracked around the 50th percentile mark generally, although her head circumference at death was closer to the 15th than the 50th percentile. Her head circumference, however, was mostly, over the period of her life, much closer to the 50th percentile than the other two parameters that were measured.

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[7] Dysplasia is defined as being the enlargement of an organ or tissue by the proliferation of cells of an abnormal type.

[8] Dr Fahy noted that the weight measurements did not state if the hip splint was on or off. However, she observed that given that the hip splint was difficult to remove that most measurements of weight were probably done with the splint on rather than off.

31. Baby C's admission to hospital on 1 January 2013 was characterised by a general absence of any concern regarding acute, significant medical issues. The hip splint was observed to be in place. Baby C was bottle fed during the first 24 hours in hospital and a total of 660mls was recorded as being consumed by her. Dr Fahy noted that the material on file indicated that she was reported as looking well, smiling and interested in her surroundings as well as being very interactive. She did, however, have an occasional moist cough and two documented loose bowel motions on 1 January. This caused her to be observed for a further 24 hours in hospital, during which time she continued to feed well. However, she had a documented weight loss of 120grams as well as expelling four stools on the day of discharge (2 January). She weighed 4.79kgs at discharge and 4.91kgs on admission. It was not specified if the hip splint (which weighed 220grams) was worn on either of these two weigh ins. It is also noteworthy that on the day of discharge Baby C was recorded as having a good urine output as well as having consumed 540mls of formula by 4pm on 2 January.

Was it appropriate to discharge Baby C on 2 January 2013?

32. There can be no question that it was appropriate to discharge Baby C from Alice Springs Hospital on 2 January. As Dr Fahy and Dr O'Connor (the chief Paediatrician at the Alice Springs Hospital at the time) stated, Baby C appeared to be medically well during her admission to the hospital. She was monitored carefully and the feeding charts that were obtained indicate that she was feeding well from bottled formula milk notwithstanding that she had, up until that point, been exclusively breast fed. She was also observed to be alert and active. The loose stools and cough were monitored appropriately on 2 January and there was nothing to indicate that Baby C suffered from any medical problem that would delay her discharge or that there was any other matter that ought to have delayed her discharge from the hospital on 2 January.

33. It is appropriate here to note that Baby C, as at the date of discharge from hospital on 2 January, was not underweight. She was a small baby but that does not mean that she was underweight. She had been growing continually throughout her life up until her time in hospital save for the very recent weight loss in hospital. What is important to recognise is, as Dr Fahy said, not the size of the baby but rather that there is consistent growth along the relevant percentile. The reality is that this had been occurring from her birth up until Baby C's discharge from hospital on 2 January. Her height plotted approximately along the third percentile, as did her weight although the latter did flatten in the month prior to 1 January and was below the third percentile at the time of her discharge on 2 January. In regard to Baby C's growth Dr Fahy does acknowledge that the lack of history in the month leading up until 1 January as well as the absence of clarity regarding the presence or not of a hip splint when weighed meant that some element of imprecision was introduced into the matter. Nevertheless, it is reasonable to assume that the hip splint was worn when weighed due to the difficulties in taking it off and, moreover, that the absence of a detailed history in the month prior to 1 January did not affect the essential matter, which is the data that was collected in regard to the key three parameters.

The admission into the care of Ms Ronda Preston

34. When Ms Preston received Baby C into her care on 2 January she had been a very experienced carer of babies, in particular, for many years. She had received a number of awards from the NT government, for her services, two of which were shown to me. She was very well known in the Alice Springs foster carer community and, consequently to the DCF administrators. Clearly, those DCF administrators reposed a great deal of trust in Ms Preston. The extent to which that occurred is apparent from the comment from the senior person in charge of DCF in Alice Springs, Ms Gabby Brown, who deposed when giving evidence at the Inquest, that she would place her own children in the care of Ms Preston. It is of further significance that Ms

Preston had never had a child die in her care during her 53-year history of being a foster carer.

35. Ms Preston gave evidence at the Inquest and referred to a number of problems that she encountered during the time that she had care of Baby C. They can be summarised as follows:

- Poor feeding habits resulting in her having to be forced fed.
- Her bowels were not operating properly[9].
- Baby C's bottom was so excoriated[10] that part of it had gone white.[11]
- No regular sleeping pattern, which caused Ms Preston (and Baby C) to have little sleep and to be up at all hours of the night.
- Constant crying.

36. The continual problem for Ms Preston was getting Baby C to eat sufficiently. To that end Ms Preston said that she obtained S21 Formula 2 bottle formula initially and then later replaced it with S21 Formula 1 formula, which is for newborn infants (whereas Formula 2 was for slightly older infants). This was for the purpose of, it would appear, assisting Baby C to consume food out of the bottle. In addition to this, Ms Preston diluted the formula that she gave Baby C. It is not clear precisely to what extent it was diluted but Ms Preston said in her interview with the police that she gave Baby C "half the amount, which was 90mls plus one and a half scoops of (S21 Formula 1)". It would appear that Ms Preston did this as she considered that this would aid her ingestion of this substance. It should be

[9] Ms Preston said in her police interview that "her bowels were shot". (p 19)
[10] The word "Excoriated" was not used by Ms Preston but, rather, she made reference to the baby's bottom bleeding and the skin being, in effect, chafed. She said that she regularly applied a medication that she referred to as "Bethane" to deal with this problem.
[11] Baby C was a dark skinned Aboriginal baby.

noted that Ms Preston implicitly considered that solids at this point were out of the question.

37. Ms Preston regarded the business of getting Baby C well again as a matter that she would pursue on a one on one basis and with considerable determination. It would appear that her track record of success was vital to her in her perception of how to address the problem. Furthermore, as she said, the fact that Baby C had come from hospital meant that in her mind she was well enough to continue on and not suffering from anything that might be life threatening. Ms Preston stated that she was well aware of the protocols that she was obliged to adhere to with DCF regarding her responsibility to contact the ambulance service or medical staff or attend the hospital if there was a need for this. She said that she was very well known at the paediatric unit of the hospital and in addition she had strong contacts with the Flynn clinic[12]. She added that she was not afraid of seeking help if the need required it. It was obvious from her evidence that she was mentally astute notwithstanding her age and that she undertook the responsibility of looking after Baby C with great dedication, which represented a continuation of what had become for her, her life's work.

38. Ms Preston said that she removed the hip brace during a bath that she gave Baby C. She did this, she said, to assist Baby C to have a bath and she was unable to get the brace back on. She rang up a person from DCF whose name she cannot recall seeking assistance in this regard. However, Ms Preston said that this person did not get back to her (nor did anybody else).

39. Ms Preston then continued to battle on with the problem of getting Baby C to feed properly and put on weight. It is important to note that Ms Preston had extensive experience in treating failure to thrive babies or babies in trauma (not that the medical records of Baby C indicated that she fitted

[12] Flynn clinic is a local medical clinic in Alice Springs.

either category). This experience, nevertheless, could only assist Ms Preston given the difficulties that she was experiencing in feeding Baby C.

40. Regarding the question of dehydration, Ms Preston testified that she was conscious of this potential problem and was sure that Baby C was not dehydrated. She said that the location of the bassinette was near sliding doors that were often open and through which a breeze would often enter from the rear garden outside. In addition to that, she had ceiling fans above the bassinette in the dining room and an air-conditioner in the same room, which she testified she used on, a regular basis. The photographs that were taken by the police crime scene specialist[13], Constable Machacek, clearly show the ceiling fans, the bassinette, the sliding doors and the air-conditioning system in close proximity to each other. It is apparent that the room and indeed all rooms of the house were scrupulously neat and clean, as described by a number of the witnesses who viewed Ms Preston's home.

41. At about 1am on the morning of 9 January, Ms Preston said that she had the ceiling fan on as well as the rear door to the dining room open for a breeze to go on to Baby C. She added that she felt that Baby C was all right.

42. Regarding Baby C's clothing, Ms Preston said that she dressed her in what would appear to be a little smock or dress and nappies.

43. Four persons who visited Ms Preston and Baby C at home gave evidence. Ms Kate Lewis, the co-ordinator of Home and Community Care with Anglicare visited Ms Preston at her home on the day prior to Baby C's death. She picked up the baby whom she noticed had laboured breathing. She thought that the baby was not very well and that she was very hot. She said that Ms Preston was concerned about Baby C's health. Ms Lewis was there for some 20 minutes and prayed for the baby. She added that it was quite hot in the room and mentioned that to Ms Preston. She said that Ms Preston said that if the air-conditioner was put on, baby gets a chill. Ms

[13] The photographs were taken shortly after the death was reported.

Lewis added that Ms Preston said that Baby C was not feeding very well and that her bowels weren't working.

44. Mr Trevor O'Neill was a support worker with Anglicare, who visited and cleaned Ms Preston's house on a regular basis. Mr O'Neill visited Ms Preston and Baby C at home, it would appear, on or about the day prior to Baby C's death. He held the baby, whom he said was very light in weight and who reminded him of babies in Africa who were occasionally shown on television. By this, I take him to mean African children in difficulties who are shown on television advertisements/programmes connected with charitable relief agencies. He added that Baby C was fed a full bottle while he was there. He said that baby was not wearing a leg brace. He said that Ms Preston said something about baby's bowels motions but he could not remember what she said. Mr O'Neill said that Ms Preston would have shown nothing but love for Baby C.

45. Ms Jennifer Holme was another employee of Anglicare. She visited Ms Preston at home on the day prior to Baby C's death. Her visit lasted about 20 minutes. Ms Holme again attested to the love and care that she had observed Ms Preston deliver to all babies in her care including Baby C. She said that Ms Preston was a wonderful foster carer. Ms Holme nursed Baby C briefly and observed that Baby C was not smiling and that Ms Preston said that she was very concerned about her bowels and also that she was having problems feeding her. Ms Holme added that Ms Preston said that if she couldn't get her eating that day that she would call the hospital the following day. Ms Holme added that Baby C was limp in her arms that she was not giggling or laughing and that she appeared to her to be not very well. Ms Holme said that she didn't feel that it was hot inside Ms Preston's home. She also said that Baby C seemed like she was sick with the flu. Ms Holme also said that she could tell from Baby C's eyes that she was really sick.

46. Ms Kleingeld was a neighbour and friend of Ms Preston. She visited Ms Preston and Baby C four separate occasions on four afternoons, at about 5pm, at Ms Preston's home. She did not recall the dates. On the first three occasions she nursed the baby. On the fourth occasion she did not touch her. On the first occasion, Ms Kleingeld noticed that she could barely hear Baby C's breath and that her eyes were dull. Baby C was cold to touch. On the second occasion, she said that Baby C was a little brighter but frail. Her temperature appeared normal and her eyes were brighter. On the third occasion Baby C appeared to have got worse and again felt very cold to touch. On the fourth occasion she thought that Baby C did not appear well and that she was going downhill. She added that she thought the baby's eyes had that "death look". However she added, "Ronda knew how to handle her".

47. Regarding the temperature in the room, Ms Kleingeld said in evidence that the sliding door was always closed when she visited and that she could not recall if the air-conditioning was on. She added that she found it to be very hot in the room because she suffered from hot flushes. In her police interview Ms Kleingeld said that the bassinette was located near the backdoor "in the cool" and that Ms Preston would often have the screen door left open to permit a cool breeze to come in from the back. She added that it was "quite a nice little unit, it's pretty cool".

48. Ms Kleingeld said that Ms Preston said to her at one point that she had only got two hours sleep over three of the days that she was looking after Baby C. She also said that Ms Preston said that the meals of milk were going straight through her. Ms Kleingeld added that on one (unspecified) occasion the baby actually smiled and kicked her feet. Ms Kleingeld added that on one of the occasions that she saw the baby she appeared to have gained weight but that on another occasion she appeared to have lost it. Although Ms Kleingeld had said in her interview with police that Baby C was a very hot little girl when she touched her, in evidence she testified that she, on

reflection said that any heat was probably attributable to the hot flushes that she was experiencing at the time. On the final occasion that she saw Baby C, which would appear to be the day prior to her death, Ms Kleingeld said that Baby C appeared to have settled down when she left. She also noted that Ms Preston was feeding Baby C every three hours.

49. Ms Kleingeld greatly valued Ms Preston's abilities and dedication as a foster care and said that she was like a 'Mother Teresa'. Ms Kleingeld said that she herself was a mother and that from a mother's viewpoint Ms Preston was looking after the baby well. Importantly, Ms Kleingeld never said in evidence that she saw the need to call for medical assistance.

FINDINGS

Cause of Death

50. As has been stated previously, Dr Sinton's initial opinion, which he stated in his autopsy report, was that the cause of death of Baby C was chronic malnutrition. He based that largely, it would seem, on the baby's low weight at death (4.01kg). He specifically stated under his Summary at the end of his report the first of the findings as being:

> "At autopsy, the significant findings include the following:
>
> (i) A low body weight (4.01kg) for her stated age of 6 months, consistent with chronic malnutrition. (The median age for her stated age is approximately 7 kgs)."

51. Dr Sinton stated in evidence before me at the Inquest that he was of the opinion that he did, in arriving at the opinion of chronic malnutrition, take into account that the baby was born eight weeks premature, (which is a factor that would have a significant impact, as previously discussed, upon an assessment as to whether Baby C could be considered, relative to her peers, to be underweight). It is important that at no point in Dr Sinton's autopsy

report did he refer to the premature birth of Baby C despite referring to her biological age on a number of occasions, and he appeared hesitant about this. I find that a Doctor of Dr Sinton's great experience and skill would have referred to the premature birth (and, consequently, the corrected age) if he had been aware of the premature birth and that it follows that by not referring to it at all in his report that there may have been a process of reconstruction that has been introduced into his recollection of this aspect of the matter. In so finding, I should hasten to add that Dr Sinton's report and evidence is, as usual, of great assistance to me.

52. I do not believe that Dr Sinton came to his opinion about chronic malnutrition knowing about the baby being born eight weeks premature.

53. It is important to observe that Dr Sinton was shown Dr Fahy's statement in which she specifically refuted chronic malnutrition as the cause of death, essentially because of the demonstrated history of the growth of the child across the three key parameters, which were all predicated upon Baby C's corrected age that allowed for her prematurity, as opposed to her biological age. Dr Sinton in evidence before me, did not reject chronic malnutrition as constituting the cause of death. He noted that Dr Fahy's two views as to the likely causes were merely possibilities. He also acknowledged that some as yet undetermined problem with the heart, which cannot according to current medical research be ascertained, might have caused Baby C's death. Hence in this context, Dr Sinton continued to press chronic malnutrition as a cause of death, which he acknowledged might have been one of a number of possible causes of the child's death. He also added that it was important to find some matter that constituted the cause of death.

54. It is important to analyse the minutiae of Dr Sinton's report. Firstly, no physical signs of injury were observed, which meant that there could be no possibility of shaken baby syndrome causing the baby's death. Secondly, the pericardium, whilst being intact and of normal thickness, contained a small

quantity of clear pale yellow fluid. Dr Sinton said that this was an indicator of something pathological, and specified that it may be consistent with heart failure. In arriving at this opinion he noted no anomalies regarding the heart and the arteries and veins leading to and from it. The liver was notably pale, which in Dr Sinton's view indicated a shortage of blood. The histology which involved microscopic examination of tissue samples of numerous key parts of Baby C's anatomy did not reveal any significant pathology. Nor did the toxicological results.

55. Dr Fahy's evidence has already being referred to extensively in these findings. It is not necessary to repeat what has already been said suffice to say this. I accept her evidence. It was comprehensive, detailed and measured. She has clearly demonstrated that Baby C grew across the three key parameters up until her time in hospital on 1-2 January 2013. The only exception to this was a slight weight loss in hospital that was noted on discharge on 2 January. Therefore, the cause of death, could not be chronic malnutrition, by definition, as there had been sustained nutritional gains over her life up until her time in hospital on 1 January. I do note, however, Dr Fahy's evidence regarding the weight loss of Baby C in the last week of her life in Ms Preston's care. Dr Fahy observed that Baby C sustained almost a 12% loss in weight if the weight of the calliper is excluded. This is significant and relevant to the cause of her death. However, in the absence of any histology results that provides evidence supporting any definite cause it is difficult to come to any concluded view. Dr Fahy postulates two causes, which she freely admits, are, in the absence of hard evidence, mere guesses. The first is dehydration that occurred as a consequence of poor feeding and diarrhoea. This could have led to salt/electrolyte disturbances or hypovolaemia. The latter condition is defined to be a reduction in the blood volume, more specifically the blood plasma level. Dr Sinton's finding regarding the paleness of the liver, which he said indicated a shortage of blood supply may be a relevant factor here, however it is impossible to

determine its connection in the absence of hard evidence. Hence, salt or electrolyte disturbances or hypervolaemia remain mere possibilities as Dr Fahy said.

56. Secondly, Dr Fahy suggested another possibility, albeit the less likely one. This was infection or sepsis in the context of some evidence of Baby C being hot. However, Dr Fahy noted that the autopsy report did not show any evidence of infection on the histology specimens. Nor were there any viral or bacterial culture results. Hence, infection as a cause of death remains a mere possibility and nothing more.

57. Dr Fahy did not rule out an unspecified heart problem as causing Baby C's death and acknowledged that there was still a lot of research being done and to be done in his area. Again, no final view could be arrived at in the absence of data.

58. It is apparent from Dr Fahy's evidence that this was not a case of SIDS (Sudden Infant Death Syndrome) as that term is used as a means of exclusion in the absence of any objective data pointing to death. This was not the case here, given the presence of low weight at death.

59. It should also be observed that Baby C had not being diagnosed as suffering from Foetal Alcohol Syndrome. Whilst there is some evidence that her mother consumed alcohol whilst pregnant with Baby C, there was no conclusive evidence at the time of Baby C's death that she suffered from this problem. Hence it can be excluded as having any role to play in the precise cause of Baby C's death.

60. In summary, it follows that I cannot come to a view based upon the evidence as to what caused the death of Baby C. Certainly, chronic malnutrition can be ruled out. But none of the other possibilities can, because of the absence of hard evidence supporting them, be stated to be the cause of death. Hence the cause of death of Baby C is undetermined.

THE ROLE OF THE DEPARTMENT OF HEALTH

61. As should be apparent from what has been stated so far I have no criticism to make of the Department of Health. They acted appropriately and as I have said I have no difficulty with the discharge of Baby C from hospital on 2 January. The absence of a discharge summary being delivered to the DCF upon discharge, whilst to be avoided, had no role to play in the death of Baby C. Nor did the matter of tubes of baby food have any relevance, tubes of food for a child of this age, being out of the question.

THE ROLE OF THE DEPARTMENT OF CHILDREN AND FAMILIES

62. I have no criticism to make of DCF. They acted appropriately. I do not criticise them for their decision to apply for Baby C to be taken into care. In any event that decision is outside the purview of these Findings. There is only one matter that did arise, which concerned Ms Preston's unanswered query to an unnamed person from the department regarding putting the callipers back on Baby C. This will be dealt with in the Recommendations. It had no role to play in the cause of Baby C's death.

THE ROLE OF THE PARENTS OF BABY C

62. I have already stated that the decision to take Baby C into care is outside the purview of these Findings. Hence, I shall focus no further attention upon the events of the early hours of 1 January 2013, nor will I peruse the DCF history of the parents of Baby C. That bears no relevance to the subject of this Inquest. I will only add for the sake of completeness that the parents bear no criminal liability in regard to Baby C and her brother being found in the car alone.

THE ROLE OF MS PRESTON

63. I find that Ms Preston was a highly skilled, extremely experienced foster mother of the highest quality. She was astute, highly determined and very caring. She has been an adornment to the community of Alice Springs for many years. Her many awards, a number from the Northern Territory

Government, are but some of the indicators of the profound level of service that she has rendered to the community of Alice Springs over many years. She frequently dealt with the most vulnerable babies in our society and did so with great love and care. Gabby Brown, the head of the DCF in Alice Springs spoke of Ms Preston being extremely well regarded in Alice Springs and having deep connections in the community, which included receiving priority treatment at the hospital. She also noted that Ms Preston had been extremely successful with failure to thrive infants before and that unofficially Ms Preston was the department's "miracle lady". It is the highest compliment to Ms Preston that Ms Brown said that she would have no hesitation in placing her own children with Ms Preston.

64. I also accept that this death has been very traumatic for Ms Preston and that as a consequence she does as she said have some gaps in her memory regarding the precise order of events. Nevertheless, I accept that she was doing her best at all times to tell the truth as to what occurred, as far as her own role is concerned, in this tragedy. Because there are some gaps in the memory of Ms Preston, this elevates the importance of the evidence of the four people who came and saw her in the last week.

65. It is also apparent that Ms Preston was very experienced with DCF protocols. She well knew to call for help when required. I find that Ms Preston was astute despite her age. I find in addition that she was very determined. It is extremely important that she possessed the view that because she knew that Baby C had come from hospital that she did not think that anything life threatening would arise.

66. In terms of the minutiae of the circumstances of the home, I find that it was impeccably clean and neat and that Ms Preston was, consonant with her experience, very well equipped to deal with Baby C. In terms of the clothing of the baby I have no difficulties with what she wore.

67. Regarding how hot the room was, there is some contradictory evidence here. On the one hand Ms Kleingeld said in evidence that it was hot because she was suffering from hot flushes. On the other hand in her interview with police that it was a cool room and that the sliding door was often open. In evidence Ms Kleingeld said that the sliding door was closed. I find that I cannot rely upon the evidence of Ms Kleingeld in relation to whether the screen door was open or closed. Regarding the heat of the room, I can place no reliance upon Ms Kleingeld's evidence that the room was hot due to her suffering from hot flushes and also due to the contradiction with what she said on this subject in the police interview. A much more reliable witness on this subject was Mr O'Neill, the Anglicare worker and cleaner who said, in evidence, that he suffers from the heat and that when he does physical work in the heat it makes it worse. He said that he didn't feel uncomfortable at all when he was there. He added that he did not recall if the ceiling fans were on. Kate Lewis said that it was quite warm in the home when she visited at about 3.30pm on the penultimate day and noted that Ms Preston said that she did not want to put the air-conditioner on for fear of giving the baby a chill. However, Ms Lewis did add that although she didn't have a specific recollection of it, the sliding door could have been open. Jennifer Holme, another foster carer and also Anglicare worker, did not find that there was a problem with the room temperature at all when she visited on the day prior to Baby C's death. She recalled that the ceiling fans were operating. In summary, and noting in particular the evidence of Mr O'Neill, Ms Lewis and Ms Holme, who would appear to me to be reliable witnesses, it is probable that the room temperature was unlikely to be hot and more likely to be at a reasonable temperature and also properly ventilated. Hence, I do not find that the matter of room ventilation and temperature were contributing factors to the death of Baby C.

68. I should also add that the fact that Ms Preston had no driver's license did not matter in the context of this case. She was centrally located in Alice

Springs and not in a remote area. Finally, in terms of feeding paraphernalia and sterilisation, Ms Preston clearly had a great deal of prior experience and skill in this regard.

69. Regarding feeding the baby I find that Ms Preston was doing her very best to feed the baby. The dilution of the milk was best avoided but nevertheless it is apparent that by virtue of the frequency of feeding and the sheer period of time that Ms Preston was spending with Baby C, at the cost of missing her own sleep, that she was doing all she could in this regard. One curious aspect of this matter is how no feeding difficulties were encountered by the hospital and yet great difficulties were encountered by a very experienced carer. I cannot determine why this occurred, but I do accept Ms Preston's evidence that she encountered great difficulties in this area as she did in relation to what were persistent problems that she experienced with Baby C's bowels.

70. Regarding the question of whether Baby C was suffering from an elevated temperature, I note, firstly, Ms Kleingeld's revised view in evidence that it was she and not the baby who was hot. Secondly, Mr O'Neill did not address this matter either in his evidence before me or in his police interview. Thirdly, Ms Lewis stated in evidence on the last day before her death that Baby C was quite warm and was breathing fast. Fourthly, Ms Holme stated that she did not have a problem with the temperature of the baby when she held her on the penultimate day. Ms Lewis was a credible witness. Her reference to quite warm as opposed to hot is significant. I find that Baby C was, in all probability at least at the time that Ms Lewis saw her on the penultimate day, quite warm (and breathing fast). Bearing in mind the significant qualification upon Ms Kleingeld's evidence that she was of a normal body temperature, the evidence does not support the finding that the baby was hot and running an elevated temperature at least at the time that she was seen on the penultimate day.

71. It is probable that at or about the penultimate day and night of Baby C's life, that Baby C's health entered a steep decline. It is certainly the case that the child experienced a significant weight loss as identified by Dr Fahy, when in the care of Ms Preston. I so find but I note that it is not clear as to when precisely this occurred. There is some basis for a view, in the light of Ms Kleingeld's evidence that she saw some improvement on the second occasion that she held Baby C, that the decline in weight tendered to occur in the latter part of the week. However, in the absence of any clear evidence on the point, it is still possible that there may have been a steady decline over the entire final week. I can express no final view on this particular point.

72. I note that the baby's head circumference was measured at 39.5cm when she was discharged from hospital on 2 January but 39cm at death. No expert commented upon this. Given the very slight difference between these measurements (0.5cm) I am prepared to accept that the difference was a human error in taking the measurement. I have already noted a number of previous miscalculations in measuring the baby's body length. I should add that the importance of taking accurate measurements cannot be emphasised enough.

73. In finding that the baby's health entered a steep decline in the care of Ms Preston, I do not criticise Ms Preston. It is vital to note that Ms Kleingeld, her friend and neighbour, who visited on four occasions in the last week, said, in effect that the baby was in the best of hands in the form of Ms Preston and, from her perspective as a mother, Ms Preston was looking after the baby well. Importantly, Ms Kleingeld never said in evidence that she saw the need to call for medical assistance. Mr O'Neill stated in evidence that the baby was in the best place in the care of Ms Preston at the time he saw her. Ms Lewis also expressed a strong view regarding the competence of Ms Preston as a carer. Finally, Ms Holme, herself a foster mother, expressed what was probably the most significant evidence of all regarding the

competence of Ms Preston's care, which was delivered in the context of the crucial penultimate day of Baby C's life: she said "I knew she wasn't well but I didn't see that it was that bad." Ms Holme had a significant amount of experience in seeing Ms Preston with babies. She thought at the time that it would be another case of Ms Preston nursing the baby through to good health. She agreed in her testimony before me with what she had said in the police interview: "the baby didn't seem stressed. It was more like you've got a flu and you could just see that the baby was quite sick". She added, in evidence "But for me, that wasn't an abnormal thing, because I had seen babies in Ronda's care before that had been sick". She agreed with my question to her that there was no way in the world that she thought that Baby C was about to die that night. She agreed that when she left Ms Preston's home that day (at about 1.45pm) that the baby was in the safe hands of Ms Preston who was giving the baby her best. Finally, Ms Holme said that Ms Preston would have rung the hospital straight away if she thought that was required.

74. It is vital that Ms Holme implicitly thought that when she left the home on 8 January, medical attention wasn't required. Further, she thought that this would be another case of seeing the baby through to good health, and, critically that she didn't see, at that time, that Baby C's health was that bad. It is also important that this opinion was expressed by no ingénue but by another experienced foster carer, who, importantly, was used to seeing babies in Ms Preston's care. Given Ms Preston's vast experience and prior success over half a century and also her view that the baby, having come from a hospital, would not be likely to suffer from anything life threatening it would seem that her decision in the circumstances to battle on as best she could was reasonable. It is always easy to be critical of people in hindsight but what must be emphasised here are the circumstances operating at the time, and the perception of Ms Preston and the key people who saw her in the final days. The extent of the care and professionalism delivered by Ms

Preston is the opposite of some scenarios that sometimes occur in circumstances such as this where lethargy on the part of the carer is the dominant paradigm. The opposite prevailed here. Clearly, Ms Preston was dynamic, energetic, extremely experienced and competent and giving her all for this baby. The extent to which Ms Preston was dedicated to this baby is illustrated by numerous matters, the final one of which is, (despite herself having very little sleep in the last days of the baby's life), the lateness of the hour that she last saw the baby alive: at about 1am on 9 January when she saw Baby C in her bassinette.

75. I note, finally, that Ms Holme said that Ms Preston said to her (on 8 January) that if the child was not better the following day that she would take her to the hospital. I find that this was said. In so finding, I acknowledge that this adds to the tragedy of what occurred. In effect, Ms Preston was backing her persistence and skill, which were forged from a history of unmitigated and continual success, to give the baby one final night to turn her health around. Tragically, this turned out to be one night too many. But put in its full context, as I have endeavoured to do, Ms Preston cannot be criticised for her role in so doing, and, moreover, in her overall care of Baby C.

76. I attach by way of an annexure recent coronial findings by a New Zealand Coroner, viz. "In the matter of Winter Kaiwaka Hine-Takurua Pira-Walker" which involves eerily (and sadly) similar circumstances, findings and comments as I make in this matter.

FORMAL FINDINGS

77. Pursuant to section 34 of the Act, I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the deceased in this case was Baby C born on 1 July 2012 at the Alice Springs Hospital, Alice Springs, Northern Territory. Baby C last resided at 5A Hong St, Gillen, Alice Springs, Northern Territory.

(ii) The time and place of death was some time between 1am (approximately) and 7am (approximately) on 9 January 2013 at 5A Hong St, Gillen, Alice Springs.

(iii) The cause of death is undetermined.

(iv) Particulars required to register the death:

(1) The deceased child was Baby C.

(2) Baby C was a baby female infant.

(3) An alleged cause of death, being chronic malnutrition, was reported to the Coroner.

(4) The cause of death cannot be determined.

(5) Baby C's parents were Ms D (mother) and Mr N (father), both of Alice Springs.

RECOMMENDATIONS

78. Baby C, given her small size and young age, was inherently fragile. Ms Preston, notwithstanding all her skill and experience was encountering difficulties with, inter alia, feeding the baby and dealing with her bowel problem. I appreciate that the Emergency Department of the Alice Springs Hospital was close at hand as was Flynn Clinic. I note, however, that Counsel Assisting has spoken to Dr Fahy and both of the Departments who appeared in this Inquest with a view to encouraging the installation of a system in Alice Springs whereby a clinical nurse or nurses, experienced in paediatric issues, would be available by telephone at first instance or in person (if necessary) to attend to any health enquiries that a foster carer looking after young babies might have such as, for example, the calliper enquiry that was raised here but also to the more important matters, such as the feeding, bowel and lethargy problems that were encountered in this case. This seems to me to be a very sensible suggestion that would in my view be likely to deliver an immediate or near immediate response to a medical

problem, the full extent of which may not be perceived by the foster carer, with the result that the problem can be quickly resolved. I understand that Dr Fahy has initiated this proposal and I commend her for it. Clearly, she has a great deal of relevant experience in the area of paediatric health in Alice Springs and her views on the matter ought to be listened to carefully. Further, I understand from counsel for both Departments that they are both receptive, at least, to the exploration of this initiative. That is encouraging. I strongly recommend that the Departments of Health and DCF work together with foster care agencies to achieve a workable protocol and practice in this regard.

Dated this 1st day of September 2014

GREG CAVANAGH
TERRITORY CORONER

CERTIFICATE OF FINDINGS

Section 94, Coroners Act 2006

IN THE MATTER of **Winter Kaiwaka Hine-Takurua PIRA-WALKER**

The Secretary, Ministry of Justice, Wellington

As the Coroner conducting the inquiry into the death of the deceased, after considering all the evidence admitted to date for its purposes, and in the light of the purposes stated in section 57 of the Coroners Act 2006, I make the following findings:

Full Name of deceased:	Winter Kaiwaka Hine-Takurua PIRA-WALKER
Late of:	662 Main Road North Upper Hutt Wellington
Occupation:	Infant
Sex:	Female
Date of Birth:	16 April 2008
Place of Death:	662 Main Road North Upper Hutt Wellington New Zealand
Date of Death:	25 December 2008
Cause(s) of Death	
(a). Direct cause:	Probable cardiac arrythmia associated with hyperkalaema

Circumstances of death (if known):

I make, under section 57(3) of the Coroners Act 2006, the attached specified recommendations or comments that; in my opinion, may, if drawn to the public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

> This has been a particularly sad case of a loss of a young life. It is clear, in my view, that the caregivers allocated to Winter were very caring and they have (along with Winter's family) felt the loss of this young child. I accept that CYFS are continually looking to improve the service delivery and that the gateway assessment scheme is one of those such steps. I still, however, feel that where the caregiver of a child changes to another caregiver, that at the slightest suspicion of any illness developing, the new caregivers seek and obtain medical advice and check out that child. This is important, in my view, because it will help to bridge the gap where care is broken from the other known providers. I also accept that the effects from dehydration in infants can be sudden and dramatic hence my comments above. I do not intend to make any recommendations as such, but leave the comments I have made for CYFS to pick up on. Finally, I wish to extend my condolences to all who cared and loved baby Winter.

My reasons for making those findings are as follows:

I find that Winter Kaiwaka Hine-Takurua Pira-Walker died at 662 Main Road North, Upper Hutt on 25 December 2008 as a result of probable cardiac arrythmia associated with hyperkalaema.

Those findings, and my reasons for making them, are also set out in my written findings dated: 18th July 2014.

Signed at Wellington on 18th day of July 2014.

Coroner Ian Smith

Decision No: 62/2014

CSU-2008-WGN-000880

IN THE CORONERS COURT
HELD AT WELLINGTON

IN THE MATTER of the Coroners Act 2006

AND

IN THE MATTER of an Inquest into the death of **WINTER KAIWAKA HINE-TAKURUA PIRA-WALKER**

Date of Death: 25th December 2008

Before: Coroner Mr I R Smith

In Attendances: Sergeant S Benge for NZ Police
Mr A A Lewis for Child, Youth & Family Service
Mr M F McClelland for Dr Brock-Smith
Ms P Walker for family

Dates of Inquest: 20th and 21st April 2011

Date of Findings: 18th July 2014

FINDINGS OF CORONER I R SMITH

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[1] Introduction

This was an inquest into the death of Winter Kaiwaka Hine-Takurua Pira-Walker, an eight month old infant who died on Christmas Day, 25 December 2008 at the residential address of 662 Main Road North, Upper Hutt. At the time of her death, Winter was under the care of Child, Youth and Family Services and was living with respite caregivers, Mr

and Mrs Fowke. Also at that address was the deceased older sister, Jeavarney, aged three and the Fowke's young children.

[2] Winter had been born four weeks' prematurely on 16 April 2008. Shortly after her birth, she developed severe eczema that required the application of lots of cream, medications and substantial care.

[3] Due to family issues including domestic violence, CYFS obtained full custody of the deceased and her three year old sister by October 2008.

[4] CYFS initially placed the children in the care of the Moeke family who were experienced caregivers with the Kokiri Marae. There were no major health problems during the time Winter spent with the Moeke family, but in December they gave approximately two weeks' notice that they required respite as they wished to go away for Christmas and that they would not be taking Winter or her sister with them.

[5] At this short notice, CYFS were able to find alternative care with the Fowke family. This family were also experienced caregivers who had over the past 10 years cared for no less than 25 children.

[6] On 19 December, the Fowkes uplifted the deceased and her sister from the CYFS office at Lower Hutt. The next day it was noticed that the older sister had developed a stomach bug, diarrhoea and had begun vomiting. Others in the family were also ill and by 22 December, Winter was also unwell. On 23 December, she was taken to see Dr Brock-Smith at the Soma Medical Centre. He examined Winter and prescribed medication, but the Fowkes did not uplift that medication until the next day on 24 December.

[7] On 24 December, a planned family access was to occur and a CYFS social worker uplifted the girls and took them to Lower Hutt.

[8] During the access visit, Winter did not look well so the family decided to cut short the visit. On the return of Winter to the Fowke's house, the prescription issued by Dr Brock-Smith had been uplifted from the pharmacy

and was immediately administered to Winter. Mrs Fowke stated that Winter appeared to be improving when she was put to bed.

[9] At about 5.00 am on Christmas morning, one of the Fowke's older children had taken Winter to Mrs Fowke. Winter was grizzly and would not take her bottle. She had her napkin changed and was dressed and was given more medicine. It was then noticed that Winter's eyes began to roll and she became unresponsive. Emergency Services were called and CPR undertaken, but Winter could not be revived.

[10] Baby Winter was subject to a post-mortem which was carried out by perinatal pathologist, Dr Jane Zuccollo. Dr Zuccollo had become concerned that baby Winter appeared malnourished and severely dehydrated. Police began an extensive investigation under the name of "Operation Season", but at the end of the investigation, they formed the opinion that there were no issues as to any criminality and their file was subsequently closed.

[11] The Court heard evidence from a Ms Jennifer Ashby-Belworthy, a qualified Plunket Nurse who had been involved with baby Winter from August 2008 up until the time of her death. She confirmed that Winter was developing as a small child for her age as far as her birth weight and length was concerned, but had no other issues regarding her care.

Evidence of Ms Tracy Satherley.

[12] Ms Satherley is a caregiver liaison social worker with the Kokiri Marae Kiriana Olsen Trust. There is an arrangement between CYFS and the Trust that where Māori children come under the care of CYFS, contact is made to the Trust to establish suitable caregivers.

[13] In this instance, the caregivers that were arranged were the Moekes who had the children from October until they asked for respite over the Christmas period.

[14] When the Moekes asked for the Christmas period respite, Ms Satherley advised CYFS that the children would have to go to other caregivers for that period, but that the Kokiri Trust had none available and that CYFS would have to arrange for some others to be involved. This was done with CYFS arranging for the children to be uplifted and placed with other foster parents during the respite period. On completion of the period of respite, CYFS would then arrange for the children to returned to the Moeke family.

[15] The Court also heard evidence from Te Aroha and Wiremu Moeke, the caregivers of the Kokiri Marae Trust that had cared for baby Winter and her sister up until they required the respite on 19 December. The Moekes had looked after a number of children over the past 10 years and were experienced caregivers. Their evidence indicated that they were great caregivers and provided a safe home for the children. Baby Winter died while they were on their holiday and they were informed of her death while in Rotorua. On their return to Wellington, Winter's older sister was returned to them for a short while.

<u>Evidence of Jolene Fowke.</u>

[16] Mrs Fowke and her husband Owen were also both experienced caregivers. They have four children aged between nine years and 16 months. One of those children is a foster child and the Fowkes have full custody and guardianship of him.

[17] The Fowkes have been involved in fostering caring for a number of years initially with Barbados, but latterly with CYFS. In the time that they have been fostering children, there had never been any complaints made about their care.

[18] In November 2008, they contacted CYFS again to say that they would like to continue fostering children as they had taken a break. The CYFS staff

came to their home to carry out a suitable check of which they were approved as suitable carers.

[19] Mrs Fowke said that on 19 December 2008, they received a telephone call from CYFS to say that there were two young children that required urgent placement for a few weeks. The ages of these children were eight months and three years respectively, but no other details were given to them at that time.

[20] Mrs Fowke had got the impression that these children had been waiting for several hours at the CYFS office and that there had been problems obtaining a placement for them at that time of the year. The Fowkes were advised that the children would be dropped off at their home later that day, but they then received a second telephone call to advise that the CYFS person (Charmaine Gibbs) was required to attend the Court at that time and as there was no one else available to bring the girls to the house, the Fowkes agreed to go and uplift them from the CYFS office. At about 2.00 o'clock that afternoon, Mrs Fowke drove with her four children down to the Lower Hutt CYFS office. The two young girls were bought out into the foyer of the office and accompanying them were their bags of clothing, some personal belongings and two car seats. Mrs Fowke was told that the youngest child, Winter, was asleep. She was in a CYFS pushchair with a cloth nappy covering her. She was also told that the girls had recently been fed and that Winter had had her nappy changed.

[21] Mrs Fowke was in the CYFS office for approximately 10 minutes and, during that time, she had a care plan handed to her. This is the document that normally accompanies the children. It was a set format care plan that contained personal details, parent's details, health issues, schooling, religion and general information about a particular child. In this instance, there was nothing mentioned about any health issues with Winter or her sister and no further instructions had been given.

[22] On arrival back home, Mrs Fowke read the care plan. She was aware that the girls were only to remain with them until 5 January 2009.

[23] Mrs Fowke noticed that Winter was a bit wheezy. She had the obvious eczema around her face and her arms and legs. Mrs Fowke noticed that Winter also appeared extremely small for her age. She was more like the size of a five to six month old child. Winter was still in a baby capsule car seat which the children usually grow out of at the age of six to eight months. Winter still had plenty of room in her capsule. Winter, however, was very mobile and was able to crawl, and was starting to spider walk.

[24] It is clear from the evidence that Mr and Mrs Fowke then began to look after the children in the appropriate manner meeting all their care needs. However, the day after the children had been uplifted, Jeavarney, the older girl, began to vomit and had diarrhoea. She did not tell anyone that she was feeling unwell as she hardly spoke, but she had begun vomiting. She did not appear miserable and was not noticed to have been running a temperature. Jeavarney continued to vomit through the evening and twice in bed that night. The following day, she vomited up several meals and drink, but by the evening had seemed to have settled down. She seemed thirstier than normal and was given lots of drinks of water.

[25] On Sunday, 21 December, Winter also started getting diarrhoea. She did not vomit, but her diarrhoea seemed to cause her quite a bad nappy rash. Winter continued to drink all her formula and was sleeping normally, although she went off solid food and appeared to be slightly grumpier than normal. She remained like this right through until 25 December.

[26] On Tuesday, 23 December, Winter seemed to have a wheezier chest. Mrs Fowke rang her own doctor at Ferguson Drive Surgery in Upper Hutt to see if they could see Winter. They were reluctant to take Winter as she was not a patient on their books and they were very busy..

[27] Mrs Fowke then contacted the CYFS office and spoke to a person there and explained the situation. That person told her that she would call Winter's normal doctor and then call back with an appointment. Mrs Fowke received a phone call shortly after to tell her that Winter's doctor's surgery did not open till 9.00 am. She was then called back shortly after to say that there was an appointment at 10.30 with Dr Ralph Brock-Smith at the Soma Medical Centre.

[28] Shortly after that, Mrs Fowke headed down to the doctor with all the children. On arrival, they were seen by a nurse who quickly examined Winter. She did temperature checks. Mrs Fowke spoke with this nurse about Winter drinking whey-based formula and whether that was a good thing when she had eczema. She provided Mrs Fowke with a printout of information on eczema.

[29] All seven people including all the children then went in to see the doctor. Mrs Fowke told Dr Brock-Smith that the reason she had bought Winter into the surgery was for the check of the wheezy chest. She also told the doctor that her sister had diarrhoea and vomiting and that Winter also now had diarrhoea.

[30] Mrs Fowke also discussed with the doctor whether Winter drinking milk formula might not be helping her illness. Dr Brock-Smith appeared to look up Winter's records on the computer and made the comment that she had been drinking formula since August that year, and said that what would be the point of changing that now. He also commented that he thought the water-based creams may not work on the eczema because the water seemed to make the enzymes worse. Dr Brock-Smith examined Winter by listening to her chest and back and checked her ears. He then determined a weight of six kilograms by weighing Winter on a set of scales.

[31] The doctor did not undress Winter with the exception of when he pulled up her clothes to listen to her chest. He gave no advice other than that the Ventolin he was prescribing was only to be given to Winter for a

couple of days when needed. Mrs Fowke had the impression that they were in the room for approximately 10 minutes. Dr Brock-Smith provided a prescription for four items; one being a steroid, one an antibiotic and the Ventolin. There was also a prescription for over the counter cough medicine which Mrs Fowke decided not to fill as Winter did not have a cough. After leaving the doctor's surgery, the family group drove straight home. Throughout that day, Winter remained the same. She continued drinking and was happy and Mrs Fowke had no concerns about her health.

[32] Later that day, Mrs Fowke received a telephone call from CYFS to say that an access visit had been arranged with the children to be with some family members for the next day. Mrs Fowke told the CYFS people about the outcome of the visit to the doctor's surgery.

[33] On Wednesday morning, Winter appeared fine. She had a sleep-in that morning. Mrs Fowke packed her bag containing prepared bottles, creams, nappies et cetera. At about 12.15 pm, a CYFS "tracker" arrived to collect the children. The children were later dropped back at the Fowke's address at about 3.00 pm. The tracker came inside as it was raining heavily. She asked that Mrs Fowke put more cream on Winter. She also mentioned that the access visit had been cut short slightly because the girls were a bit unwell. When Mrs Fowke went through the bag, she noticed that Winter's bottle of formula had been partially drunk. Some of her baby food had been opened, but was not completely eaten. Later when she changed Winter's nappy, she noticed it was not very wet so she assumed that either her nappy was changed during the access visit or she had not wet it.

[34] At about 3.30 pm, Mrs Fowke took Winter with her to do some Christmas shopping. They went to the Upper Hutt shopping area. When they first arrived, it was noticed that Winter had filled her nappy with diarrhoea. While in town, they went to the Radius Pharmacy and picked up the prescription for Winter. She was given her first dose of all three items while in town. Winter took the medicine fine. She was given a second dose of those medicines that evening before she went to bed.

[35] When the family got home, Winter's nappy was changed again and it was noticed that she still had a small amount of diarrhoea. She was otherwise fine and continued feeding every one to one and a half hours drinking about 100 to 150 millilitres. Winter was put to bed at about 7.30 pm and prior to that she had been very happy playing with the musical toys in the lounge. She was alert and mobile. She had her usual bedtime bottle of about 150 mils immediately before going to bed. She then finished the milk and was put to sleep.

[36] Early the next morning at approximately 5.00 am, Mrs Fowke's oldest son had gone upstairs with Winter in his arms. Winter was making some light noises. Mrs Fowke took Winter and went downstairs and prepared some formula for her. She attempted to give her the formula but Winter rejected it. Winter's chest sounded very wheezy. She then changed Winter's nappy noticing her bottom was raw from nappy rash but was not bleeding. More cream was reapplied.

[37] Winter had begun to make a funny moaning noise and Mrs Fowke noticed that her eyes were rolling backwards and that they looked slightly sunken. Winter's skin appeared pale. Mrs Fowke decided to call for an ambulance. She continued to look after Winter while waiting for the services to arrive, but Winter stopped breathing while in her arms. She began CPR. The ambulance staff arrived, but shortly after they pronounced Winter as deceased. Both police and the CYFS staff were then alerted.

[38] Mr and Mrs Fowke were devastated at Winter's death. They still look back on this and wonder what they could have done differently. Sometimes the tragedy of her death comes back to remind them every Christmas. The Fowkes recognise as well the emotional impact this would have had on her family and her sister. It will not fade away for them.

Evidence of Mrs Maharangi Gilbert.

[39] Mrs Gilbert is a care and protection supervisor for CYFS and has worked for between 17 and 18 years in the frontline. Mrs Gilbert was the on-call superior during the 2008/2009 holiday period.

[40] Mrs Gilbert's first contact with the family was in September 2008 leading up to an FGC (family group conference). She stated that CYFS advised the family that they were not going to support the family/whānau having the care of Winter and her sister due to the grandmother and partner's incidents of domestic violence. The outcome after the FGC was a Court order on 21 October that the children come into the care of the Chief Executive of CYFS and placed with the Kokiri Marae social services caregiver, Jossy Moeke.

[41] Mrs Gilbert said she was involved on 24 December when they had to intervene and terminate the access visit as when she saw Winter at that time, Winter looked sick and dehydrated. Mrs Gilbert thought that Winter may have had a flu-like illness. Mrs Gilbert says that she instructed another staff member to talk to Mrs Fowke about Winter's condition on return of the child to them.

[42] I put it to Mrs Gilbert that as she thought that Winter was unwell, why did she not intervene further to ensure that the baby was seen by a doctor at that time. In reply, Mrs Gilbert thought that she had significantly advised the CYFS person, who was to take the children back to the Fowkes, to see that steps were taken, but she did not specifically advise of a visit required of a doctor.

[43] On the day of the truncated visit, the weather had been bad with heavy rain. The family questioned Mrs Gilbert as to why it still went ahead with a sick baby being subject to wet weather. Mrs Gilbert responded that a decision had been made that Winter must have been well enough to attend.

The family's response to that was, "You do not bring sick children out in the rain."

Evidence of Ms Janet Evelyn Bell.

[44] The Court heard evidence from Ms Bell who is a resource worker for CYFS. She has been in that role for some four and a half years. That role is mainly one of supervision, that is, a duty to pick up children, supervise and observe visits with family and whānau. Ms Bell then takes the children back to their caregivers and then writes a report for the social worker.

[45] Ms Bell first became involved with the Pira family in November 2008 when she took the two girls to visit the grandparents, Lania and Malcolm Pira at Petone. Her observations of those visits with the grandparents was that they were clearly a caring family and understood their grandchildren's needs.

[46] With regards to Winter's health, Ms Bell best described it as being up and down. She said Winter would have colds and coughs and Ms Bell knew that Winter had the skin condition of eczema from her first visit with the family. This was fairly obvious by the flaking, peeling and wrinkling of the skin over her face and legs.

[47] Ms Bell said that approximately a week to 10 days before Christmas, she had asked the Kokiri caregivers what they were going to be doing over Christmas and they told her that they were going up north to family. They also told her that they would not be taking the children and that there would have to be alternative care arrangements made. There was no conversation between them as to whom or where the children were going to go. Although initially there was no concern about the arrangements for a respite carer, as time got closer to Christmas, the Kokiri caregivers did become concerned that they had not heard from CYFS about where the children were to go.

[48] Ms Bell received an email dated 22 December that informed her of the new pick up arrangements for the children. Her computer server was down and she did not receive that email until later that week.

[49] Ms Bell learnt that the children were now to be placed at an address in Upper Hutt. Due to the distance that Ms Bell would have to travel and the time, it did not leave enough time to pick up the children on that particular access day. In addition, she was advised that the caregiver was not happy to allow the children to go out as Winter was unwell. The visit was therefore cancelled and Ms Bell found out the next day from Mrs Fowke that Winter had gone to the doctor on 23 December. It was her understanding about the doctor's visit was for bronchial asthma and that she did not know that Winter had diarrhoea.

[50] An arrangement was then made for the visit to take place on 24 December with Lania and Malcolm. She thought that because the children were allowed to visit the family, they must have been better. On 24 December 2008, at approximately 1.00 pm, Ms Bell arrived at the caregiver's home in Upper Hutt to pick up the children. She noticed at that time the girls were pleased to see her. She was a familiar face, but they did not seem to be their usual happy selves probably due to being in a different place and also not feeling well. When Ms Bell first saw Winter that day, she noticed that her tongue was poking out which was really unusual. She had never done that before. Her tongue remained poking out the whole time she was with them on that visit. Ms Bell thought it might have been something to do with the asthma or a sore throat or a blocked nose. Ms Bell knew that Winter was on antibiotics for her asthma and she thought that the caregiver had this under control. Because the weather outside was wet and cold, she made sure that Winter was warm enough for the trip down to the CYFS offices in Lower Hutt. Ms Bell had the impression that the caregiver was not happy about the children going out in the cold.

[51] Ms Bell thought that Winter sounded distressed and expressed this concern with the social worker at the office. It was then that she learnt that

Winter had been seen by the doctor the day before. The visit with the grandparents went ahead, but after a while it was decided by all present that the visit should be concluded and the children were returned to the Fowkes' home.

[52] It was put to Ms Bell as to what instructions had she been given by Mrs Gilbert as to what she should convey to the Fowke family about Winter being unwell. She replied that she was unaware of any instructions having been given. As Winter was looking unwell, she stated that she had assumed, having been informed that Winter had been to see the doctor the day before, everything was under control.

[53] Evidence of Ms Jo Field. Ms Field is the General Manager Residential Services of CYFS and had overall responsibility for CYFS delivery for the central region that included the Hutt Valley. Her evidence dealt with Winter's care with Kokiri Social Service caregivers and the care with the Fowke family.

[54] Turning to Winter's care with the Fowke family, this respite care was required over the Christmas period as the Kokiri Marae Social Services caregivers had decided to go away at that time. This care was arranged quite quickly. CYFS, through their caregiver liaison team, had one week to arrange the new respite caregivers. Mr and Mrs Fowke were advised and agreed to take the children on 19 December.

[55] Ms Field commented that it would have been helpful for this to have been arranged sooner, but there were often short timeframes for organising respite care and finding a caregiver over the Christmas period can be particularly challenging. In the circumstances given, the time of the year, the process took place as quickly as it could have done.

[56] Winter and Jeavarney were placed with the Fowke family who were experienced CYFS approved caregivers. Mr and Mrs Fowke had looked after 21 different children during their time as CYFS caregivers including

infants prior to Winter and Jeavarney placement. Jolyn Fowke was a trained nanny and childbirth educator, and was very experienced in caring for young children. A care plan was in place for Winter and was provided to Jolyn Fowke on 19 December. That care plan provided information about how to treat Winter's eczema, her dietary requirements, eating and sleeping habits. Winter's eczema cream was also given to Mrs Fowke.

[57] Ms Field commented that CYFS are committed to learning on how to improve their services and to look after the welfare of young children in their care, and were willing to learn from the determination that the Coroner brings down in this matter. Given that, I commented that where a young child is in CYFS care and is in the process of passing through several caregivers, such as the respite care that brought about Winter's transfer to the Fowkes, then if CYFS are aware that a child is unwell, the service needs to err on the side of caution and see that appropriate medical treatment and information is carried. Ms Field agreed and would take that comment on board.

<u>Evidence of Dr Ralph Brock-Smith.</u>

[58] Dr Brock-Smith is a General Practitioner practising at the Soma Medical Centre. He stated that since Winter's birth in April of 2008, she had been registered at his practice. He first saw her in August 2008 with the condition eczema. Shortly after her birth, she was noted to have serious reoccurring problems with infected eczema. Her condition could be described as severe, almost her whole body being covered.

[59] On 5 November 2008, Winter was seen by a locum for gastroenteritis. Winter had been vomiting with watery diarrhoea. This had settled by her next examination on 27 November when seen for a viral upper respiratory infection. Dr Brock-Smith said that Winter responded quickly to the treatment given which was Augmentin (for five days), Redipred (for four days) and Ventolin (an oral bronchodilator to treat the wheeze).

[60] When Dr Brock-Smith next saw Winter on 23 December 2008, she was in a clinical condition that did appear similar to her condition on 27 November. Winter was given another similar short course of antibiotics for six days, Redipred for three to four days, Ventolin orally and Robitussin Mucolytic directed at clearing the wheezy bronchitis. As with the previous causes, these medications were also chosen to clear the eczema except that this time Augmentin was avoided because it might have caused diarrhoea and instead she was given Erythromycin which would very seldom make diarrhoea worse.

[61] Dr Brock-Smith stated that there was a mention of diarrhoea on the day of that visit, although the nurse who saw Winter at first recorded that she had been told Winter had loose bowel motions. There was no history of vomiting and it was not noted that she was dehydrated. He said signs of dehydration, however, can be subtle. The most objective signs such as rapid pulse were attributed to her being sick with fever. Weight would not routinely have been measured in a child presenting acutely with bronchitis and eczema and any weight loss may have been partially related to distress from her social circumstances. The symptoms of gastroenteritis were mild, less than those on 27 November 2008 and this appeared the least of the three medical problems that he had seen on 23 December.

[62] Dr Brock-Smith said that he worked on 23 December from 8.00 am to approximately 11.00 pm that day. He believed that his nurse saw Winter for about seven minutes before he spent 14 minutes examining the child. He considered the two primary concerns that day were the state of Winter's eczema and the wheezy bronchitis. He was aware that Mrs Fowke advised him of Winter's diarrhoea, but that his assessment of that was that it was of a mild form of gastroenteritis.

<u>Evidence of Dr Jane Zuccollo.</u>

[63] Dr Zuccollo is a Perinatal Pathologist who completed an autopsy on baby Winter on 26 December 2008. She concluded that the cause of death

was from probable cardiac arrhythmia associated with hypokalemia, secondary to dehydration associated with diarrhoea illness.

[64] Dr Zuccollo went on to explain that she had concluded that the cause of death was probable cardiac arrhythmia associated with hypokalemia, secondary to the dehydration associated with the diarrhoea. Dr Zuccollo said that the child came to autopsy and looked very clearly dehydrated. The eyes were sunken, the skin had poor turgor and the internal organs were extremely sticky and stuck to the examining glove, and this was a feature she had observed in similar cases where there was significant dehydration. An examination of vitreous fluid, which was the most stable fluid in a dead body and in Winter's case, to her surprise, the vitreous potassium was extremely high, so high in fact that Dr Zuccollo questioned whether there was laboratory error.

[65] Dr Zuccollo identified no viruses at all from the bowel contents or from anywhere else that she had cultured. Dr Zuccollo had to take notice of the very heavy potassium in view of the fact that she thought the baby had died of dehydration or with the dehydration. Winter was also remarkably low weight for her age of eight months. Dr Zuccollo concluded that the probability of a cardiac arrhythmia associated with the high potassium that is essentially an intracellular electrolyte when it leaks out of the sick cells, the free potassium that measured was significant, particularly to a cardiac function and the cells of the heart muscles were very sensitive to high levels of potassium and the effects of those high levels of circulated potassium are that they might cause cardiac arrest. The heart may just stop. A very high level of potassium had to be interpreted in the light of potassium that normally arises after death, but Dr Zuccollo could not recall potassium higher than 16 in an infant of this age even after several days following post-mortem interval. Dr Zuccollo also said that in respect to dehydration from previous cases that she had performed on autopsies that clinically it is a difficult matter to detect. She had seen two children that were omitted to hospital and discharged home and died at home, and the level of dehydration was not appreciated clinically on those babies. She said this was a difficult

condition and it can happen very rapidly in that Winter's deterioration happened overnight that it was most likely a terminal vent was that of the kidney failure possibly releasing even more potassium into the circulation.

[66] Dr Zuccollo commented that children can rapidly die of dehydration. When a child is sick, the signs may be obviously unwell. They do not respond to the illnesses as adults do and children can go down very rapidly.

Evidence of Dr Phillip Jeffrey Brown.

[67] Dr Brown was called by Mr Lewis as an expert witness. Dr Brown is a consultant paediatrician and had extensive experience in assessing and managing gastroenteritis and dehydration in children. Dr Brown was able to conclude that Winter's caregivers had sought medical assessment and advice during her illness, and the observations that she was drinking and not acting significantly different from normal in the hours before her tragic death led him to advise that the caregivers' care and attention was not substandard.

[68] Dr Brown stated that importantly for Winter and her caregivers, a medical assessment had been sought from a practitioner and a practice who were her regular medical home. This assessment was that she was alert and only had an upper respiratory tract infection. There was no diagnosis of dehydration or gastroenteritis nor any other treatment advised for those. Her caregivers could not be expected to assess that she was seriously dehydrated when they had been reassured, and when her skin condition and small size makes signs of dehydration even more difficult to detect. Dr Brown said, in fact, that she had a viral gastroenteritis as evidenced by family members suffering a like illness and that the post-mortem findings indicating death from dehydration leading to circuitry failure probably complicated by cardiac arrhythmia and hypokalemia. At such a young age and small size, the fluid loss that could have led to her death may have only been around 600 millilitres and she may well have gone from compensated shock (fluid loss compensated with few circuitry signs of compromise) to uncompromised

shock (collapse of her circulation) in a matter of hours to minutes. That this happened during the night was unfortunate, but it could not be blamed on the caregivers.

[69] Dr Brown referred to a new "gateway assessment scheme" being undertaken by CYFS and the Court has subsequently received a copy of that scheme which was to be rolled out nationally in the 2011 budget. The objective of the pilot scheme was to adopt the following points.

- Improve the health and development trajectory of each child and young person who came into the care by facilitating access to appropriate health, education and disability sought support services.

- Identify the health and education needs of each child and young person.

- Support each child, young person and their family/whānau and/or caregiver in meeting the health needs of the child or the young person.

- Provide an ongoing patient held record for each child so the records would shift with them if they moved placements to ensure they receive continuity of care from healthcare providers.

Coroner's Comments

[70] This has been a particularly sad case of a loss of a young life. It is clear, in my view, that the caregivers allocated to Winter were very caring and they have (along with Winter's family) felt the loss of this young child. I accept that CYFS are continually looking to improve the service delivery and that the gateway assessment scheme is one of those such steps. I still, however, feel that where the caregiver of a child changes to another

caregiver, that at the slightest suspicion of any illness developing, the new caregivers seek and obtain medical advice and check out that child. This is important, in my view, because it will help to bridge the gap where care is broken from the other known providers. I also accept that the effects from dehydration in infants can be sudden and dramatic hence my comments above. I do not intend to make any recommendations as such, but leave the comments I have made for CYFS to pick up on. Finally, I wish to extend my condolences to all who cared and loved baby Winter.

CODA

i. A copy of the provisional findings were sent out to the Counsel, Police, and family of the deceased on 21st May. This was to enable any party pursuant to S58(3) of the Coroners Act to comment on any aspect of the findings they might consider to be adverse in nature.

ii. A submission was received from Mr A Lewis on behalf of the Ministry of Social Development on the 4th July 2014. Mr Lewis had also attempted to contact former caregivers involved with this matter so that they had the opportunity to make any submission.

iii. No other submission was received.

iv. I have considered the submission and I have made an adjustment to paragraph 39 in accordance with Mr Lewis' submission.

v. With respect to the rest of the submission made the comments are noted but the findings remain as provisionally made.

Verdict

[71] I find that Winter Kaiwaka Hine-Takurua Pira-Walker died at 662 Main Road North, Upper Hutt on 25 December 2008 as a result of probable cardiac arrythmia associated with hyperkalaema.

Signed this 18th day of July 2014 at Wellington

Ian Roderick Smith
Coroner