ORDER:
Restricting the publication of any report of the matter which discloses N's name and the names of any of her carers and/or anything that may identify the carers.

CITATION: *Inquest into the death of N* [2012] NTMC 037

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0160/2011
DELIVERED ON:	29 October 2012
DELIVERED AT:	Darwin
HEARING DATE(s):	26 October 2012
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Care, mandatory inquest, No criticism or recommendations**

REPRESENTATION:

Counsel Assisting:	Sally Ozolins

Judgment category classification:	A
Judgement ID number:	[2012] NTMC 037
Number of paragraphs:	31
Number of pages:	8

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0160/2011

In the matter of an Inquest into the death of a child**:**

N

ON 27 SEPTEMBER 2011
AT ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. N is an Aboriginal female born on 25 October 2001 at the Royal Darwin Hospital. She died of aspiration pneumonia resulting from cerebral palsy and seizures whilst in the Intensive Care Unit (ICU) at Royal Darwin Hospital (RDH) on 27 September 2011. N was nine years old at the time of her death.

2. It is a reportable death as N was a child in the care of the CEO as defined by section 12(1)(a) of the *Coroners Act* (the Act) at the time of her death. Consequently and pursuant to section 15(1)(a) the holding of an inquest was mandatory.

3. Deputy Coroner Sally Ozolins appeared as Counsel Assisting. The death was investigated by Detective Senior Constable Glen Chatto. I received into evidence his detailed investigation brief in addition to medical files relating to N and files relating to her custody and care from the Department of Children and Families (DCF). I also heard evidence from N's primary carer, Ms D.

4. Pursuant to section 34 of 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 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*; and
>
> (v) any relevant circumstances concerning the death ..."

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

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

6. Additionally, I may make recommendations pursuant to section 35(1), (2) & (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."

Background

7. N was born prematurely on 25 October 2001 at the Royal Darwin Hospital to a 13 year old mother and an un-named father at 31 weeks gestation. N's birth weight was 1.81 kilograms.

8. N was born with severe cerebral palsy in addition to severe cognitive impairment and cortical blindness. She developed contractures (the chronic loss of joint motion) and had a long term seizure disorder which caused her to suffer seizures of short duration on a daily basis throughout her life despite regular anti-epileptic medication. N suffered with excessive oral secretions for which she was medicated. N suffered from gastroesophageal disease and underwent a fundoplication (surgical procedure in which the stomach is wrapped around the oesophagus to prevent vomiting) and later developed bronchieactasis.

9. N spent the first months of her life as an in-patient at either the Katherine District Hospital (KDH) or the RDH. A significant medical issue throughout this period was feeding and N failed to gain weight. She underwent gastronomy and the insertion of a percutaneous endoscopic gastrostomy (PEG).

10. From time to time N was released into the care of an aunty, as N's mother was not able to provide adequate care for her given her medical conditions and also due to the fact that the mother was so young. The aunty would take N to Ngukurr to visit family however neither she nor other family members were able to provide the intensive level of complex care that N required.

11. On 11 August 2003, N was ordered pursuant to the *Care and Protection of Children Act* to be placed into the care of the Minister. From that time until her death N was a 'person held in care' as defined in the Act.

12. In 2003 N was placed into the residential custody of Ms D, a registered carer with the Life Without Barriers organisation. With the exception of some

brief respite periods and periods during which N was hospitalised, N remained in Ms D's consistent care for her entire life.

13. N had no mobility. She was fully dependent and used an attendant propelled wheelchair. She relied on carers for all of her living needs and continued to suffer seizures, sometimes multiple every day throughout her life. N was unable to speak however she was able to 'vocalise' sounds and had developed a way of communicating with Ms D and other carers. Ms D described in evidence how she was able to interpret the body language, movements and sounds made by N to determine what she needed or wanted.

14. It is apparent that Ms D and N had a loving, strong and close relationship. Ms D cared for N as if she were her own child and was described by observers to be devoted to and well attuned to N's needs, taking very good care of her. Records indicate that Ms D was keenly aware of and concerned about the needs of N and brought issues to the attention of the school and DCF when problems arose in relation to her health or other needs. Ms D was clearly emotional and profoundly affected by N's death. Incidentally, in 2008 Ms D was named the national Disability Support Person of the Year for her contribution to caring for people with disabilities. There is no doubt that Ms D provided a high level of care to N.

15. N regularly saw a number of health professionals including general practitioners, paediatricians and other special needs professionals and was monitored on an on-going and regular basis.

16. From about 2005 N attended the Kintore Street Special Needs School. She was encouraged to be actively involved and to participate in school program which helped build positive encouragement and also gave N an opportunity to interact with others in both familiar and unfamiliar surroundings. Opportunities for physical and verbal interaction were encouraged. Therapy intervention at the school included alternate positioning trials and trial of

equipment such as standing frames to promote muscle and joint strengthening.

17. Family members, including N's biological mother visited N from time to time in Katherine and were reportedly happy with the living and care arrangements for N.

Events leading up to final hospitalisation

18. On 12 September 2011 N was reviewed by Paediatrician, Dr Monique Stone at Katherine. Ms D reported that N had suffered an increased rate of seizures for the previous three days. She was also suffering from constipation and bronchiectasis. Dr Stone suggested an increase in anti-seizure medication and oral anti-biotics to address an inflammation of the PEG site.

19. In the afternoon of the following day N suffered further seizures which could not be stabilised. Ms D rang an ambulance which conveyed N to KDH.

20. N quickly developed status epilepticus, a condition in which the brain is in a state of persistent seizure, which was complicated by aspiration pneumonia. Doctors sought to control the seizures and intubated N to facilitate her conveyance to RDH on a 'care flight'.

21. N arrived at the Emergency Department at RDH at 2:10am on 14 September 2011 and she was transferred to the ICU shortly thereafter. Medical staff were able to control the seizures to some extent and the aspiration pneumonia improved. Consequently, N was extubated and moved to the paediatric ward on 18 September 2011.

22. However, from 20 September 2011 N's condition deteriorated and she developed worsening pneumonia. She was re-intubated and returned to ICU where mechanical ventilation was instituted and N was administered broad

spectrum antibiotics and anti epileptic medication. N's clinical status did not improve and over the ensuing week deterioration in her renal function was noted. N's poor prognosis was discussed with both Ms D and N's biological family.

23. On 27 September 2011 and in consultation with N's family who had been brought to Darwin by DCF, a determination was made to desist from on-going invasive management and to direct care to making N as comfortable as possible.

24. N was extubated at 5:00pm on 27 September 2011 and passed away an hour later.

Report to the Coroner

25. The death was reported to the Coroner on 30 September 2011 by Dr Sara Watson of RDH. Dr Watson's statement, sworn 12 March 2012 indicates that she reported the death to the Coroner on 29 September 2011 however has since acknowledged that it could have been the 30th as recorded by the Deputy Coroner and Coroner's constables. It seems that the death was not immediately reported either by the medical staff or DCF due to a misunderstanding of the requirement to report it.

26. Dr Gabriele Weidmann, an Intensive Care Specialist was present when N died and endorsed a medical certificate on which she noted that the cause of death was known, namely aspiration pneumonia with morbid conditions of cerebral palsy and seizures giving rise to the cause of death. She also 'ticked' a printed box to indicate that the death was a 'non-Coroners Case'. Dr Weidmann indicated in her statement that at the time she was unaware that the death was a reportable death.

27. Ms Stephanie Fielder, the Regional Director for DCF based in Katherine acknowledged in her statement that whilst DCF complied with its own internal reporting procedures relating to N's death, it failed to report the

death to the Coroner. Ms Fielder acknowledged that senior members of staff in the area were unaware of their responsibility to report deaths in these circumstances. The oversight was attributed to a high turnover of staff resulting in staff members acting in the higher management roles and not being fully aware of all obligations.

28. Efforts have been made since N's death to ensure that DCF staff are aware of obligations pursuant to the Act. A regional training officer in Katherine has since been appointed to provide staff with local support in relation to training and development and to ensure that DCF staff are consistently and continuously updated in relation to legislative and policy requirements.

Cause of death

29. Notwithstanding the delay in reporting the death to the Coroner, the cause of death is not in issue. The disease or condition directly leading to the death of this much loved little girl was aspiration pneumonia. Morbid conditions contributing to her death were cerebral palsy and seizures.

Recommendations

30. There are no recommendations arising from this inquest.

Formal Findings

31. On the basis of the tendered material and oral evidence given at this inquest, I am able to make the following formal findings in relation to the death of N, as required by the Act:

    i. N was born on 25 October 2001 in Darwin in the Northern Territory of Australia.

    ii. The time and place of death was at approximately 6.00 pm on 27 September 2011 at the Royal Darwin Hospital.

    iii. The cause of death was aspiration pneumonia. Other significant conditions contributing to death but not

related to the condition causing death were Cerebral Palsy and seizures.

iv. Particulars required to register the death:

a. N was female.

b. N's name was N.

c. N was of Aboriginal descent.

d. The cause of death was reported to the Coroner.

e. The cause of death was confirmed by Intensive Care Specialist, Dr Gabriele Weidmann after an autopsy was deemed unnecessary.

f. N's mother was Joanne W and her father is unknown.

g. N lived at an un-named address in Katherine in the Northern Territory of Australia;

h. N was unemployed.

Dated this 29th day of October 2012 day of 2012.

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GREG CAVANAGH
TERRITORY CORONER